ICD-9-CM Official Guidelines for Coding and Reporting

Effective October 1, 2011

Narrative changes appear in bold text

Items underlined have been moved within the guidelines since October 1, 2010

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). These guidelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are included on the official government version of the ICD-9-CM, and also appear in "*Coding Clinic for ICD-9-CM*" published by the AHA.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in Volumes I, II and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Volumes 1-2) have been adopted under HIPAA for all healthcare settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting.

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Section I. Conventions, general coding guidelines and chapter specific guidelines

The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

A. Conventions for the ICD-9-CM

The conventions for the ICD-9-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the index and tabular of the ICD-9-CM as instructional notes. The conventions are as follows:

1. Format:

The ICD-9-CM uses an indented format for ease in reference

2. Abbreviations

a. Index abbreviations

NEC "Not elsewhere classifiable"
This abbreviation in the index represents "other specified" when a specific code is not available for a condition the index directs the coder to the "other specified" code in the tabular.

b. Tabular abbreviations

NEC "Not elsewhere classifiable"
This abbreviation in the tabular represents "other specified". When a specific code is not available for a condition the tabular includes an NEC entry under a code to identify the code as the "other specified" code.
(See Section I.A.5.a. "Other" codes").

NOS "Not otherwise specified"
This abbreviation is the equivalent of unspecified.
(See Section I.A.5.b., "Unspecified" codes)

3. Punctuation

[ ] Brackets are used in the tabular list to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the index to identify manifestation codes.
(See Section I.A.6. "Etiology/manifestations")

( ) Parentheses are used in both the index and tabular to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is

assigned. The terms within the parentheses are referred to as nonessential modifiers.

: Colons are used in the Tabular list after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

4. Includes and Excludes Notes and Inclusion terms

Includes: This note appears immediately under a three-digit code title to further define, or give examples of, the content of the category.

Excludes: An excludes note under a code indicates that the terms excluded from the code are to be coded elsewhere. In some cases the codes for the excluded terms should not be used in conjunction with the code from which it is excluded. An example of this is a congenital condition excluded from an acquired form of the same condition. The congenital and acquired codes should not be used together. In other cases, the excluded terms may be used together with an excluded code. An example of this is when fractures of different bones are coded to different codes. Both codes may be used together if both types of fractures are present.

Inclusion terms: List of terms is included under certain four and five digit codes. These terms are the conditions for which that code number is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the index may also be assigned to a code.

5. Other and Unspecified codes

a. "Other" codes

Codes titled "other" or "other specified" (usually a code with a 4th digit 8 or fifth-digit 9 for diagnosis codes) are for use when the information in the medical record provides detail for which a specific code does not exist. Index entries with NEC in the line designate "other" codes in the tabular. These index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.

b. "Unspecified" codes

Codes (usually a code with a 4th digit 9 or 5th digit 0 for diagnosis codes) titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code.

6. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes a "use additional code" note will still be present and the rules for sequencing apply.

In addition to the notes in the tabular, these conditions also have a specific index entry structure. In the index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

The most commonly used etiology/manifestation combinations are the codes for Diabetes mellitus, category 250. For each code under category 250 there is a use additional code note for the manifestation that is specific for that particular diabetic manifestation. Should a patient have more than one manifestation of diabetes, more than one code from category 250 may be used with as many manifestation codes as are needed to fully describe the patient's complete diabetic condition. The category 250 diabetes codes should be sequenced first, followed by the manifestation codes.

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.
See - Section I.B.9. "Multiple coding for a single condition".

7. "And"

The word "and" should be interpreted to mean either "and" or "or" when it appears in a title.

8. "With"

The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

The word "with" in the alphabetic index is sequenced immediately following the main term, not in alphabetical order.

9. "See" and "See Also"

The "see" instruction following a main term in the index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code.

A "see also" instruction following a main term in the index instructs that there is another main term that may also be referenced that may provide additional index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code.

B. General Coding Guidelines

1. Use of Both Alphabetic Index and Tabular List

Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity in code selection.

2. Locate each term in the Alphabetic Index

Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

3. Level of Detail in Coding

Diagnosis and procedure codes are to be used at their highest number of digits available.

ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.

A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. For example, Acute myocardial infarction, code 410, has fourth digits that describe the location of the infarction (e.g., 410.2, Of inferolateral wall), and fifth digits that identify the episode of care. It would be incorrect to report a code in category 410 without a fourth and fifth digit.

ICD-9-CM Volume 3 procedure codes are composed of codes with either 3 or 4 digits. Codes with two digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of third and/or fourth digits, which provide greater detail.

4. Code or codes from 001.0 through V91.99

The appropriate code or codes from 001.0 through V91.99 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

5. Selection of codes 001.0 through 999.9

The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the admission/encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g., infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).

6. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.

7. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

8. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

9. Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. "Use additional code" notes are found in the tabular at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair - "use additional code" indicates that a secondary code should be added.

For example, for infections that are not included in chapter 1, a secondary code from category 041, Bacterial infection in conditions classified elsewhere and of unspecified site, may be required to identify the bacterial organism causing the infection. A "use additional code" note will normally be found at

the infectious disease code, indicating a need for the organism code to be added as a secondary code.

"Code first" notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When a "code first" note is present and an underlying condition is present the underlying condition should be sequenced first.

"Code, if applicable, any causal condition first", notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

10. Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

11. Combination Code

A combination code is a single code used to classify:
Two diagnoses, or
A diagnosis with an associated secondary process (manifestation)
A diagnosis with an associated complication

Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

12. Late Effects

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two

codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

Exceptions to the above guidelines are those instances where the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s) **or the classification instructs otherwise.** The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

13. Impending or Threatened Condition

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

If it did occur, code as confirmed diagnosis.
If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for "impending" or "threatened" and also reference main term entries for "Impending" and for "Threatened."
If the subterms are listed, assign the given code.
If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

14. Reporting Same Diagnosis Code More than Once

Each unique ICD-9-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions or two different conditions classified to the same ICD-9-CM diagnosis code.

15. Admissions/Encounters for Rehabilitation

When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis.

Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter. A procedure code should be reported to identify each type of rehabilitation therapy actually performed.

16. Documentation for BMI and Pressure Ulcer Stages

For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often documents the pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient's

provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

The BMI and pressure ulcer stage codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the BMI and pressure ulcer stage codes should only be assigned when they meet the definition of a reportable additional diagnosis (see Section III, Reporting Additional Diagnoses).

17. Syndromes

Follow the Alphabetic Index guidance when coding syndromes. In the absence of index guidance, assign codes for the documented manifestations of the syndrome.

18. Documentation of Complications of care

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

C. Chapter-Specific Coding Guidelines

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings. Please refer to Section II for guidelines on the selection of principal diagnosis.

1. Chapter 1: Infectious and Parasitic Diseases (001-139)

a. Human Immunodeficiency Virus (HIV) Infections

1) Code only confirmed cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, "confirmation" does not require documentation of positive serology or culture for HIV; the provider's

diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

2) Selection and sequencing of HIV codes

(a) **Patient admitted for HIV-related condition**

If a patient is admitted for an HIV-related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV-related conditions.

(b) **Patient with HIV disease admitted for unrelated condition**

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be 042 followed by additional diagnosis codes for all reported HIV-related conditions.

(c) **Whether the patient is newly diagnosed**

Whether the patient is newly diagnosed or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.

(d) **Asymptomatic human immunodeficiency virus**

V08 Asymptomatic human immunodeficiency virus [HIV] infection, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases.

(e) **Patients with inconclusive HIV serology**

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code 795.71, Inconclusive serologic test for Human Immunodeficiency Virus [HIV].

(f) **Previously diagnosed HIV-related illness**

Patients with any known prior diagnosis of an HIV-related illness should be coded to 042. Once a patient has developed an HIV-related illness, the patient

should always be assigned code 042 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.

(g) **HIV Infection in Pregnancy, Childbirth and the Puerperium**

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of 647.6X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of 647.6X and V08.

(h) **Encounters for testing for HIV**

If a patient is being seen to determine his/her HIV status, use code V73.89, Screening for other specified viral disease. Use code V69.8, Other problems related to lifestyle, as a secondary code if an asymptomatic patient is in a known high risk group for HIV. Should a patient with signs or symptoms or illness, or a confirmed HIV related diagnosis be tested for HIV, code the signs and symptoms or the diagnosis. An additional counseling code V65.44 may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his/her HIV test results use code V65.44, HIV counseling, if the results of the test are negative.

If the results are positive but the patient is asymptomatic use code V08, Asymptomatic HIV infection. If the results are positive and the patient is symptomatic use code 042, HIV infection, with codes for the HIV related symptoms or diagnosis. The HIV counseling code may also be used if counseling is provided for patients with positive test results.

b. Septicemia, Systemic Inflammatory Response Syndrome (SIRS), Sepsis, Severe Sepsis, and Septic Shock

1) SIRS, Septicemia, and Sepsis

(a) The terms *septicemia* and *sepsis* are often used interchangeably by providers, however they are not considered synonymous terms. The following descriptions are provided for reference but do not preclude querying the provider for clarification about terms used in the documentation:

(i) Septicemia generally refers to a systemic disease associated with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi or other organisms.

(ii) Systemic inflammatory response syndrome (SIRS) generally refers to the systemic response to infection, trauma/burns, or other insult (such as cancer) with symptoms including fever, tachycardia, tachypnea, and leukocytosis.

(iii) Sepsis generally refers to SIRS due to infection.

(iv) Severe sepsis generally refers to sepsis with associated acute organ dysfunction.

(b) **The Coding of SIRS, sepsis and severe sepsis**

The coding of SIRS, sepsis and severe sepsis requires a minimum of 2 codes: a code for the underlying cause (such as infection or trauma) and a code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).

(i) The code for the underlying cause (such as infection or trauma) must be sequenced before the code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).

(ii) Sepsis and severe sepsis require a code for the systemic infection (038.xx, 112.5, etc.) and either code 995.91, Sepsis, or 995.92, Severe sepsis. If the causal organism is not documented, assign code 038.9, Unspecified septicemia.

(iii) Severe sepsis requires additional code(s) for the associated acute organ dysfunction(s).

(iv) If a patient has sepsis with multiple organ dysfunctions, follow the instructions for coding severe sepsis.

(v) Either the term sepsis or SIRS must be documented to assign a code from subcategory 995.9.

(vi) See Section I.C.17.g), Injury and poisoning, for information regarding systemic inflammatory response syndrome (SIRS) due to trauma/burns and other non-infectious processes.

(c) Due to the complex nature of sepsis and severe sepsis, some cases may require querying the provider prior to assignment of the codes.

2) Sequencing sepsis and severe sepsis

(a) **Sepsis and severe sepsis as principal diagnosis**

If sepsis or severe sepsis is present on admission, and meets the definition of principal diagnosis, the systemic infection code (e.g., 038.xx, 112.5, etc) should be assigned as the principal diagnosis, followed by code 995.91, Sepsis, or 995.92, Severe sepsis, as required by the sequencing rules in the Tabular List. Codes from subcategory 995.9 can never be assigned as a principal diagnosis. A code should also be assigned for any localized infection, if present.

If the sepsis or severe sepsis is due to a postprocedural infection, see Section I.C.1.b.10 for guidelines related to sepsis due to postprocedural infection.

(b) **Sepsis and severe sepsis as secondary diagnoses**

When sepsis or severe sepsis develops during the encounter (it was not present on admission), the systemic infection code and code 995.91 or 995.92 should be assigned as secondary diagnoses.

(c) **Documentation unclear as to whether sepsis or severe sepsis is present on admission**

Sepsis or severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear

whether the sepsis or severe sepsis was present on admission, the provider should be queried.

3) Sepsis/SIRS with Localized Infection

If the reason for admission is both sepsis, severe sepsis, or SIRS and a localized infection, such as pneumonia or cellulitis, a code for the systemic infection (038.xx, 112.5, etc) should be assigned first, then code 995.91 or 995.92, followed by the code for the localized infection. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/SIRS doesn't develop until after admission, see guideline I.C.1.b.2.b).

If the localized infection is postprocedural, *see Section I.C.1.b.10 for guidelines related to sepsis due to postprocedural infection.*

Note: The term urosepsis is a nonspecific term. If that is the only term documented then only code 599.0 should be assigned based on the default for the term in the ICD-9-CM index, in addition to the code for the causal organism if known.

4) Bacterial Sepsis and Septicemia

In most cases, it will be a code from category 038, Septicemia, that will be used in conjunction with a code from subcategory 995.9 such as the following:

(a) **Streptococcal sepsis**

If the documentation in the record states streptococcal sepsis, codes 038.0, Streptococcal septicemia, and code 995.91 should be used, in that sequence.

(b) **Streptococcal septicemia**

If the documentation states streptococcal septicemia, only code 038.0 should be assigned, however, the provider should be queried whether the patient has sepsis, an infection with SIRS.

5) Acute organ dysfunction that is not clearly associated with the sepsis

If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign code 995.92, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not

clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

6) Septic shock

(a) **Sequencing of septic shock and postprocedural septic shock**

Septic shock generally refers to circulatory failure associated with severe sepsis, and, therefore, it represents a type of acute organ dysfunction.

For cases of septic shock, the code for the systemic infection should be sequenced first, followed by codes 995.92, **Severe sepsis** and 785.52**, Septic shock or 998.02, Postoperative septic shock**. Any additional codes for other acute organ dysfunctions should also be assigned. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

(b) **Septic shock and postprocedural septic shock without documentation of severe sepsis**

Since septic shock indicates the presence of severe sepsis, **c**ode 995.92, Severe sepsis, **can be** assigned with code 785.52, Septic shock, **or code 998.02 Postoperative shock, septic,** even if the term severe sepsis is not documented in the record.

7) Sepsis and septic shock complicating abortion and pregnancy

Sepsis and septic shock complicating abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630-639).
See section I.C.11.i.7. for information on the coding of puerperal sepsis.

8) Negative or inconclusive blood cultures

Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia or sepsis in patients with clinical evidence of the condition, however, the provider should be queried.

9) Newborn sepsis

See Section I.C.15.j for information on the coding of newborn sepsis.

10) Sepsis due to a Postprocedural Infection

(a) **Documentation of causal relationship**

As with all postprocedural complications, code assignment is based on the provider's documentation of the relationship between the infection and the procedure.

(b) **Sepsis due to postprocedural infection**

In cases of postprocedural sepsis, the complication code, such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and either code 995.91or 995.92). An additional code(s) for any acute organ dysfunction should also be assigned for cases of severe sepsis.

See Section see Section I.C.1.b.6 if the sepsis or severe sepsis results in postprocedural septic shock.

(c) **Postprocedural infection and postprocedural septic shock**

In cases where a postprocedural infection has occurred and has resulted in severe sepsis and postprocedural septic shock, the code for the precipitating complication such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and code 995.92). Code 998.02, Postoperative septic shock, should be assigned as an additional code. In cases of severe sepsis, an additional code(s) for any acute organ dysfunction should also be assigned.

11) External cause of injury codes with SIRS

Refer to Section I.C.19.a.7 for instruction on the use of external cause of injury codes with codes for SIRS resulting from trauma.

12) Sepsis and Severe Sepsis Associated with Non-infectious Process

In some cases, a non-infectious process, such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a

non-infectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the non-infectious condition should be sequenced first, followed by the code for the systemic infection and either code 995.91, Sepsis, or 995.92, Severe sepsis. Additional codes for any associated acute organ dysfunction(s) should also be assigned for cases of severe sepsis. If the sepsis or severe sepsis meets the definition of principal diagnosis, the systemic infection and sepsis codes should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the sepsis or severe sepsis meet the definition of principal diagnosis, either may be assigned as principal diagnosis.

See Section I.C.1.b.2.a. for guidelines pertaining to sepsis or severe sepsis as the principal diagnosis.

Only one code from subcategory 995.9 should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in sepsis or severe sepsis, assign either code 995.91 or 995.92. Do not additionally assign code 995.93, Systemic inflammatory response syndrome due to non-infectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome with acute organ dysfunction.

See Section I.C.17.g for information on the coding of SIRS due to trauma/burns or other non-infectious disease processes.

c. Methicillin Resistant *Staphylococcus aureus* (MRSA) Conditions

1) Selection and sequencing of MRSA codes

(a) Combination codes for MRSA infection

When a patient is diagnosed with an infection that is due to methicillin resistant *Staphylococcus aureus* (MRSA), and that infection has a combination code that includes the causal organism (e.g., septicemia, pneumonia) assign the appropriate code for the condition (e.g., code 038.12, Methicillin resistant Staphylococcus aureus septicemia or code 482.42, Methicillin resistant pneumonia due to Staphylococcus aureus). Do not assign code 041.12, Methicillin resistant Staphylococcus aureus, as an additional code because the code includes the type of infection and the

MRSA organism. Do not assign a code from subcategory V09.0, Infection with microorganisms resistant to penicillins, as an additional diagnosis.

See Section C.1.b.1 for instructions on coding and sequencing of septicemia.

(b) **Other codes for MRSA infection**

When there is documentation of a current infection (e.g., wound infection, stitch abscess, urinary tract infection) due to MRSA, and that infection does not have a combination code that includes the causal organism, select the appropriate code to identify the condition along with code 041.12, Methicillin resistant Staphylococcus aureus, for the MRSA infection. Do not assign a code from subcategory V09.0, Infection with microorganisms resistant to penicillins.

(c) **Methicillin susceptible Staphylococcus aureus (MSSA) and MRSA colonization**

The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier. Colonization means that MSSA or MSRA is present on or in the body without necessarily causing illness. A positive MRSA colonization test might be documented by the provider as "MRSA screen positive" or "MRSA nasal swab positive".

Assign code V02.54, Carrier or suspected carrier, Methicillin resistant Staphylococcus aureus, for patients documented as having MRSA colonization. Assign code V02.53, Carrier or suspected carrier, Methicillin susceptible Staphylococcus aureus, for patient documented as having MSSA colonization. Colonization is not necessarily indicative of a disease process or as the cause of a specific condition the patient may have unless documented as such by the provider.

Code V02.59, Other specified bacterial diseases, should be assigned for other types of staphylococcal colonization (e.g., S. *epidermidis, S. saprophyticus).* Code V02.59 should not be assigned for colonization with any type of *Staphylococcus aureus* (MRSA, MSSA).

(d) **MRSA colonization and infection**

If a patient is documented as having both MRSA colonization and infection during a hospital admission, code V02.54, Carrier or suspected carrier, Methicillin resistant *Staphylococcus aureus*, and a code for the MRSA infection may both be assigned.

2. Chapter 2: Neoplasms (140-239)

General guidelines

Chapter 2 of the ICD-9-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters. To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates "adenoma," refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to "see also neoplasm, by site, benign." The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The tabular should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist. *See Section I. C. 18.d.4. for information regarding V codes for genetic susceptibility to cancer.*

a. Treatment directed at the malignancy

If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.

The only exception to this guideline is if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign the appropriate V58.x code as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.

b. Treatment of secondary site

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

c. Coding and sequencing of complications

Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:

1) Anemia associated with malignancy

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy.

Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy.

If anemia in neoplastic disease and anemia due to antineoplastic chemotherapy are both documented**, assign codes for both conditions.**

2) Anemia associated with chemotherapy, immunotherapy and radiation therapy

When the admission/encounter is for management of an anemia associated with chemotherapy, immunotherapy or radiotherapy and the only treatment is for the anemia, the anemia is sequenced first. The appropriate neoplasm code should be assigned as an additional code.

3) Management of dehydration due to the malignancy

When the admission/encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.

4) Treatment of a complication resulting from a surgical procedure

When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

d. Primary malignancy previously excised

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and

there is no evidence of any existing primary malignancy, a code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the V10 code used as a secondary code.

e. Admissions/Encounters involving chemotherapy, immunotherapy and radiation therapy

1) Episode of care involves surgical removal of neoplasm

When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the neoplasm code should be assigned as principal or first-listed diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.

2) Patient admission/encounter solely for administration of chemotherapy, immunotherapy and radiation therapy

If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign code V58.0, Encounter for radiation therapy, or V58.11, Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence.

The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

3) Patient admitted for radiotherapy/chemotherapy and immunotherapy and develops complications

When a patient is admitted for the purpose of radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is V58.0, Encounter for radiotherapy, or V58.11, Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.

f. Admission/encounter to determine extent of malignancy

When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

g. Symptoms, signs, and ill-defined conditions listed in Chapter 16 associated with neoplasms

Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

h. Admission/encounter for pain control/management

See Section I.C.6.a.5 for information on coding admission/encounter for pain control/management.

i. Malignant neoplasm associated with transplanted organ

A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from subcategory 996.8, Complications of transplanted organ, followed by code 199.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

3. Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)

a. Diabetes mellitus

Codes under category 250, Diabetes mellitus, identify complications/manifestations associated with diabetes mellitus. A fifth-digit is required for all category 250 codes to identify the type of diabetes mellitus and whether the diabetes is controlled or uncontrolled.

See I.C.3.a.7 for secondary diabetes

1) Fifth-digits for category 250:

The following are the fifth-digits for the codes under category 250:

0 type II or unspecified type, not stated as uncontrolled
1 type I, [juvenile type], not stated as uncontrolled
2 type II or unspecified type, uncontrolled

3 type I, [juvenile type], uncontrolled

The age of a patient is not the sole determining factor, though most type I diabetics develop the condition before reaching puberty. For this reason type I diabetes mellitus is also referred to as juvenile diabetes.

2) Type of diabetes mellitus not documented

If the type of diabetes mellitus is not documented in the medical record the default is type II.

3) Diabetes mellitus and the use of insulin

All type I diabetics must use insulin to replace what their bodies do not produce. However, the use of insulin does not mean that a patient is a type I diabetic. Some patients with type II diabetes mellitus are unable to control their blood sugar through diet and oral medication alone and do require insulin. If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, the appropriate fifth-digit for type II must be used. For type II patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code V58.67 should not be assigned if insulin is given temporarily to bring a type II patient's blood sugar under control during an encounter.

4) Assigning and sequencing diabetes codes and associated conditions

When assigning codes for diabetes and its associated conditions, the code(s) from category 250 must be sequenced before the codes for the associated conditions. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification *(See Section I.A.6., Etiology/manifestation convention).* Assign as many codes from category 250 as needed to identify all of the associated conditions that the patient has. The corresponding secondary codes are listed under each of the diabetes codes.

(a) Diabetic retinopathy/diabetic macular edema

Diabetic macular edema, code 362.07, is only present with diabetic retinopathy. Another code from subcategory 362.0, Diabetic retinopathy, must be used with code 362.07. Codes under subcategory 362.0 are diabetes manifestation codes, so they must be used following the appropriate diabetes code.

5) Diabetes mellitus in pregnancy and gestational diabetes

(a) For diabetes mellitus complicating pregnancy, see Section I.C.11.f., Diabetes mellitus in pregnancy.

(b) For gestational diabetes, see Section I.C.11, g., Gestational diabetes.

6) Insulin pump malfunction

(a) **Underdose of insulin due insulin pump failure**

An underdose of insulin due to an insulin pump failure should be assigned 996.57, Mechanical complication due to insulin pump, as the principal or first listed code, followed by the appropriate diabetes mellitus code based on documentation.

(b) **Overdose of insulin due to insulin pump failure**

The principal or first listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be 996.57, Mechanical complication due to insulin pump, followed by code 962.3, Poisoning by insulins and antidiabetic agents, and the appropriate diabetes mellitus code based on documentation.

7) Secondary Diabetes Mellitus

Codes under category 249, Secondary diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

(a) **Fifth-digits for category 249:**

A fifth-digit is required for all category 249 codes to identify whether the diabetes is controlled or uncontrolled.

(b) **Secondary diabetes mellitus and the use of insulin**

For patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned. Code V58.67 should not be assigned if insulin is given temporarily to bring a patient's blood sugar under control during an encounter.

(c) **Assigning and sequencing secondary diabetes codes and associated conditions**

When assigning codes for secondary diabetes and its associated conditions (e.g. renal manifestations), the code(s) from category 249 must be sequenced before the codes for the associated conditions. The secondary diabetes codes and the diabetic manifestation codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification. Assign as many codes from category 249 as needed to identify all of the associated conditions that the patient has. The corresponding codes for the associated conditions are listed under each of the secondary diabetes codes. For example, secondary diabetes with diabetic nephrosis is assigned to code 249.40, followed by 581.81.

(d) **Assigning and sequencing secondary diabetes codes and its causes**

The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the reason for the encounter, applicable ICD-9-CM sequencing conventions, and chapter-specific guidelines.

If a patient is seen for treatment of the secondary diabetes or one of its associated conditions, a code from category 249 is sequenced as the principal or first-listed diagnosis, with the cause of the secondary diabetes (e.g. cystic fibrosis) sequenced as an additional diagnosis.

If, however, the patient is seen for the treatment of the condition causing the secondary diabetes (e.g., malignant neoplasm of pancreas), the code for the cause of the secondary diabetes should be sequenced as the principal or first-listed diagnosis followed by a code from category 249.

(i) Secondary diabetes mellitus due to pancreatectomy

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code 251.3, Postsurgical hypoinsulinemia. Assign a code from subcategory 249**,** Secondary diabetes mellitus and a code from subcategory V88.1, Acquired absence of pancreas as additional

codes. Code also any diabetic manifestations (e.g. diabetic nephrosis 581.81).

(ii) Secondary diabetes due to drugs

Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning.
See section I.C.17.e for coding of adverse effects and poisoning, and section I.C.19 for E code reporting.

4. Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)

a. Anemia of chronic disease

Subcategory 285.2, Anemia in chronic illness, has codes for anemia in chronic kidney disease, code 285.21; anemia in neoplastic disease, code 285.22; and anemia in other chronic illness, code 285.29. These codes can be used as the principal/first listed code if the reason for the encounter is to treat the anemia. They may also be used as secondary codes if treatment of the anemia is a component of an encounter, but not the primary reason for the encounter. When using a code from subcategory 285 it is also necessary to use the code for the chronic condition causing the anemia.

1) Anemia in chronic kidney disease

When assigning code 285.21, Anemia in chronic kidney disease, it is also necessary to assign a code from category 585, Chronic kidney disease, to indicate the stage of chronic kidney disease.
See I.C.10.a. Chronic kidney disease (CKD).

2) Anemia in neoplastic disease

When assigning code 285.22, Anemia in neoplastic disease, it is also necessary to assign the neoplasm code that is responsible for the anemia. Code 285.22 is for use for anemia that is due to the malignancy, not for anemia due to antineoplastic chemotherapy drugs. Assign **the appropriate code** for anemia due to antineoplastic chemotherapy.
See I.C.2.c.1 Anemia associated with malignancy.
See I.C.2.c.2 Anemia associated with chemotherapy, immunotherapy and radiation therapy.

5. Chapter 5: Mental Disorders (290-319)

Reserved for future guideline expansion

6. Chapter 6: Diseases of Nervous System and Sense Organs (320-389)

a. Pain - Category 338

1) General coding information

Codes in category 338 may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated below.

If the pain is not specified as acute or chronic, do not assign codes from category 338, except for post-thoracotomy pain, postoperative pain, neoplasm related pain, or central pain syndrome.

A code from subcategories 338.1 and 338.2 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/ management and not management of the underlying condition.

(a) **Category 338 Codes as Principal or First-Listed Diagnosis**

Category 338 codes are acceptable as principal diagnosis or the first-listed code:

- When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.

- When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category 338 should be assigned.

- When a patient is admitted for the insertion of a neurostimulator for pain control, assign the

appropriate pain code as the principal or first listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

(b) **Use of Category 338 Codes in Conjunction with Site Specific Pain Codes**

(i) Assigning Category 338 Codes and Site-Specific Pain Codes

Codes from category 338 may be used in conjunction with codes that identify the site of pain (including codes from chapter 16) if the category 338 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

(ii) Sequencing of Category 338 Codes with Site-Specific Pain Codes

The sequencing of category 338 codes with site-specific pain codes (including chapter 16 codes), is dependent on the circumstances of the encounter/admission as follows:

- If the encounter is for pain control or pain management, assign the code from category 338 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code 338.11, Acute pain due to trauma, followed by code 723.1, Cervicalgia, to identify the site of pain).

- If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category 338.

2) Pain due to devices, implants and grafts

Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. Use additional code(s) from category 338 to identify acute or chronic pain due to presence of the device, implant or graft (338.18-338.19 or 338.28-338.29).

3) Postoperative Pain

Post-thoracotomy pain and other postoperative pain are classified to subcategories 338.1 and 338.2, depending on whether the pain is acute or chronic. The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.

Routine or expected postoperative pain immediately after surgery should not be coded.

(a) **Postoperative pain not associated with specific postoperative complication**

Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category 338.

(b) **Postoperative pain associated with specific postoperative complication**

Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. If appropriate, use additional code(s) from category 338 to identify acute or chronic pain (338.18 or 338.28). If pain control/management is the reason for the encounter, a code from category 338 should be assigned as the principal or first-listed diagnosis in accordance with *Section I.C.6.a.1.a above*.

(c) **Postoperative pain as principal or first-listed diagnosis**

Postoperative pain may be reported as the principal or first-listed diagnosis when the stated reason for the admission/encounter is documented as postoperative pain control/management.

(d) **Postoperative pain as secondary diagnosis**

Postoperative pain may be reported as a secondary diagnosis code when a patient presents for outpatient

surgery and develops an unusual or inordinate amount of postoperative pain.

The provider's documentation should be used to guide the coding of postoperative pain, as well as *Section III. Reporting Additional Diagnoses* and *Section IV. Diagnostic Coding and Reporting in the Outpatient Setting.*

See Section II.I.2 for information on sequencing of diagnoses for patients admitted to hospital inpatient care following post-operative observation.

See Section II.J for information on sequencing of diagnoses for patients admitted to hospital inpatient care from outpatient surgery.

See Section IV.A.2 for information on sequencing of diagnoses for patients admitted for observation.

4) Chronic pain

Chronic pain is classified to subcategory 338.2. There is no time frame defining when pain becomes chronic pain. The provider's documentation should be used to guide use of these codes.

5) Neoplasm Related Pain

Code 338.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.

This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.

When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code 338.3 may be assigned as an additional diagnosis.

See Section I.C.2 for instructions on the sequencing of neoplasms for all other stated reasons for the admission/encounter (except for pain control/pain management).

6) Chronic pain syndrome

This condition is different than the term "chronic pain," and therefore this code should only be used when the provider has specifically documented this condition.

b. Glaucoma

1) Glaucoma

For types of glaucoma classified to subcategories 365.1-365.6, an additional code should be assigned from subcategory 365.7, Glaucoma stage, to identify the glaucoma stage. Codes from 365.7, Glaucoma stage, may not be assigned as a principal or first-listed diagnosis.

2) Bilateral glaucoma with same stage

When a patient has bilateral glaucoma and both are documented as being the same type and stage, report only the code for the type of glaucoma and one code for the stage.

3) Bilateral glaucoma stage with different stages

When a patient has bilateral glaucoma and each eye is documented as having a different stage, assign one code for the type of glaucoma and one code for the highest glaucoma stage.

4) Bilateral glaucoma with different types and different stages

When a patient has bilateral glaucoma and each eye is documented as having a different type and a different stage, assign one code for each type of glaucoma and one code for the highest glaucoma stage.

5) Patient admitted with glaucoma and stage evolves during the admission

If a patient is admitted with glaucoma and the stage progresses during the admission, assign the code for highest stage documented.

6) Indeterminate stage glaucoma

Assignment of code 365.74, Indeterminate stage glaucoma, should be based on the clinical documentation. Code 365.74 is used for glaucomas whose stage cannot be clinically determined. This code should not be confused with code 365.70, Glaucoma stage, unspecified. Code

365.70 should be assigned when there is no documentation regarding the stage of the glaucoma.

7. Chapter 7: Diseases of Circulatory System (390-459)

a. Hypertension

Hypertension Table

The Hypertension Table, found under the main term, "Hypertension", in the Alphabetic Index, contains a complete listing of all conditions due to or associated with hypertension and classifies them according to malignant, benign, and unspecified.

1) Hypertension, Essential, or NOS

Assign hypertension (arterial) (essential) (primary) (systemic) (NOS) to category code 401 with the appropriate fourth digit to indicate malignant (.0), benign (.1), or unspecified (.9). Do not use either .0 malignant or .1 benign unless medical record documentation supports such a designation.

2) Hypertension with Heart Disease

Heart conditions (425.8, 429.0-429.3, 429.8, 429.9) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category 428 to identify the type of heart failure in those patients with heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

The same heart conditions (425.8, 429.0-429.3, 429.8, 429.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.

3) Hypertensive Chronic Kidney Disease

Assign codes from category 403, Hypertensive chronic kidney disease, when conditions classified to category 585 or code 587 are present with hypertension. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies chronic kidney disease (CKD) with hypertension as hypertensive chronic kidney disease.

Fifth digits for category 403 should be assigned as follows:

- 0 with CKD stage I through stage IV, or unspecified.
- 1 with CKD stage V or end stage renal disease.

The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 403 to identify the stage of chronic kidney disease.

See Section I.C.10.a for information on the coding of chronic kidney disease.

4) Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category 404, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. Assign an additional code from category 428, to identify the type of heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

Fifth digits for category 404 should be assigned as follows:

- 0 without heart failure and with chronic kidney disease (CKD) stage I through stage IV, or unspecified
- 1 with heart failure and with CKD stage I through stage IV, or unspecified
- 2 without heart failure and with CKD stage V or end stage renal disease
- 3 with heart failure and with CKD stage V or end stage renal disease

The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 404 to identify the stage of kidney disease.
See Section I.C.10.a for information on the coding of chronic kidney disease.

5) Hypertensive Cerebrovascular Disease

First assign codes from 430-438, Cerebrovascular disease, then the appropriate hypertension code from categories 401-405.

6) Hypertensive Retinopathy

Two codes are necessary to identify the condition. First assign the code from subcategory 362.11, Hypertensive retinopathy, then the appropriate code from categories 401-405 to indicate the type of hypertension.

7) Hypertension, Secondary

Two codes are required: one to identify the underlying etiology and one from category 405 to identify the hypertension.

Sequencing of codes is determined by the reason for admission/encounter.

8) Hypertension, Transient

Assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code 642.3x for transient hypertension of pregnancy.

9) Hypertension, Controlled

Assign appropriate code from categories 401-405. This diagnostic statement usually refers to an existing state of hypertension under control by therapy.

10) Hypertension, Uncontrolled

Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories 401-405 to designate the stage and type of hypertension. Code to the type of hypertension.

11) Elevated Blood Pressure

For a statement of elevated blood pressure without further specificity, assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, rather than a code from category 401.

b. Cerebral infarction/stroke/cerebrovascular accident (CVA)

The terms stroke and CVA are often used interchangeably to refer to a cerebral infarction. The terms stroke, CVA, and cerebral infarction NOS are all indexed to the default code 434.91, Cerebral artery occlusion, unspecified, with infarction.

Additional code(s) should be assigned for any neurologic deficits associated with the acute CVA, regardless of whether or not the neurologic deficit resolves prior to discharge.

See Section I.C.18.d.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

c. Postoperative cerebrovascular accident

A cerebrovascular hemorrhage or infarction that occurs as a result of medical intervention is coded to 997.02, Iatrogenic cerebrovascular infarction or hemorrhage. Medical record documentation should clearly specify the cause- and-effect relationship between the medical

intervention and the cerebrovascular accident in order to assign this code. A secondary code from the code range 430-432 or from a code from subcategories 433 or 434 with a fifth digit of "1" should also be used to identify the type of hemorrhage or infarct.

This guideline conforms to the use additional code note instruction at category 997. Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used as a secondary code with code 997.02.

d. Late Effects of Cerebrovascular Disease

1) Category 438, Late Effects of Cerebrovascular disease

Category 438 is used to indicate conditions classifiable to categories 430-437 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to 430-437. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to 430-437.

Codes in category 438 are only for use for late effects of cerebrovascular disease, not for neurologic deficits associated with an acute CVA.

2) Codes from category 438 with codes from 430-437

Codes from category 438 may be assigned on a health care record with codes from 430-437, if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

3) Code V12.54

Assign code V12.54, Transient ischemic attack (TIA), and cerebral infarction without residual deficits (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

e. Acute myocardial infarction (AMI)

1) ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)

The ICD-9-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories 410.0-410.6 and 410.8 are used for ST elevation myocardial infarction (STEMI). Subcategory 410.7, Subendocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

2) Acute myocardial infarction, unspecified

Subcategory 410.9 is the default for the unspecified term acute myocardial infarction. If only STEMI or transmural MI without the site is documented, query the provider as to the site, or assign a code from subcategory 410.9.

3) AMI documented as nontransmural or subendocardial but site provided

If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI. If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

See Section I.C.18.d.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

8. Chapter 8: Diseases of Respiratory System (460-519)

See I.C.17.f. for ventilator-associated pneumonia.

a. Chronic Obstructive Pulmonary Disease [COPD] and Asthma

1) Conditions that comprise COPD and Asthma

The conditions that comprise COPD are obstructive chronic bronchitis, subcategory 491.2, and emphysema, category 492. All asthma codes are under category 493, Asthma. Code 496, Chronic airway obstruction, not elsewhere classified, is a nonspecific code that should only be used when the documentation in a medical record does not specify the type of COPD being treated.

2) Acute exacerbation of chronic obstructive bronchitis and asthma

The codes for chronic obstructive bronchitis and asthma distinguish between uncomplicated cases and those in acute exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

3) Overlapping nature of the conditions that comprise COPD and asthma

Due to the overlapping nature of the conditions that make up COPD and asthma, there are many variations in the way these conditions are documented. Code selection must be based on the terms as documented. When selecting the correct code for the documented type of COPD and asthma, it is essential to first review the index, and then verify the code in the tabular list. There are many instructional notes under the different COPD subcategories and codes. It is important that all such notes be reviewed to assure correct code assignment.

4) Acute exacerbation of asthma and status asthmaticus

An acute exacerbation of asthma is an increased severity of the asthma symptoms, such as wheezing and shortness of breath. Status asthmaticus refers to a patient's failure to respond to therapy administered during an asthmatic episode and is a life threatening complication that requires emergency care. If status asthmaticus is documented by the provider with any type of COPD or with acute bronchitis, the status asthmaticus should be sequenced first. It supersedes any type of COPD including that with acute exacerbation or acute bronchitis. It is inappropriate to assign an asthma code with 5th digit 2, with acute exacerbation, together with an asthma code with 5th digit 1, with status asthmatics. Only the 5th digit 1 should be assigned.

b. Chronic Obstructive Pulmonary Disease [COPD] and Bronchitis

1) Acute bronchitis with COPD

Acute bronchitis, code 466.0, is due to an infectious organism. When acute bronchitis is documented with COPD, code 491.22, Obstructive chronic bronchitis with acute bronchitis, should be assigned. It is not necessary to also assign code 466.0. If a medical record documents acute bronchitis with COPD with acute exacerbation, only code 491.22 should be assigned. The acute bronchitis included in code 491.22 supersedes the acute exacerbation. If a medical record documents COPD with acute exacerbation without mention of acute bronchitis, only code 491.21 should be assigned.

c. Acute Respiratory Failure

1) Acute respiratory failure as principal diagnosis

Acute respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.

2) Acute respiratory failure as secondary diagnosis

Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.

3) Sequencing of acute respiratory failure and another acute condition

When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis *(Section II, C.)* may be applied in these situations.

If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.

d. Influenza due to certain identified viruses

Code only confirmed cases of avian influenza (code**s** 488.01-488.02, 488.09, Influenza due to identified avian influenza virus)**, 2009** H1N1 influenza virus (code**s** 488.11-488.12, 488.19)**, or novel influenza A (codes 488.81-488.82, 488.89, Influenza due to identified novel influenza A virus).** This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).

In this context, "confirmation" does not require documentation of positive laboratory testing specific for avian**, 2009 H1N1** or novel influenza **A virus**. However, coding should be based on the provider's diagnostic statement that the patient has avian **influenza, 2009 H1N1 influenza,** or novel influenza **A.**

If the provider records "suspected**"** or "possible**"** or **"**probable**"** avian**, 2009 H1N1,** or novel influenza **A,** the appropriate influenza code from category 487**, Influenza** should be assigned. A code from category 488, Influenza due to certain identified influenza viruses, should not be assigned.

9. Chapter 9: Diseases of Digestive System (520-579)

Reserved for future guideline expansion

10. Chapter 10: Diseases of Genitourinary System (580-629)

a. Chronic kidney disease

1) Stages of chronic kidney disease (CKD)

The ICD-9-CM classifies CKD based on severity. The severity of CKD is designated by stages I-V. Stage II, code 585.2, equates to mild CKD; stage III, code 585.3, equates to moderate CKD; and stage IV, code 585.4, equates to severe CKD. Code 585.6, End stage renal disease (ESRD), is assigned when the provider has documented end-stage-renal disease (ESRD).

If both a stage of CKD and ESRD are documented, assign code 585.6 only.

2) Chronic kidney disease and kidney transplant status

Patients who have undergone kidney transplant may still have some form of CKD, because the kidney transplant may not fully restore kidney function. Therefore, the presence of CKD alone does not constitute a transplant complication. Assign the appropriate 585 code for the patient's stage of CKD and code V42.0. If a transplant complication such as failure or rejection is documented, see section I.C.17.f.2.b for information on coding complications of a kidney transplant. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

3) Chronic kidney disease with other conditions

Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the tabular list.
See I.C.3.a.4 for sequencing instructions for diabetes.

See I.C.4.a.1 for anemia in CKD.
See I.C.7.a.3 for hypertensive chronic kidney disease.
See I.C.17.f.2.b, Kidney transplant complications, for instructions on coding of documented rejection or failure.

11. Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-679)

a. General Rules for Obstetric Cases

1) Codes from chapter 11 and sequencing priority

Obstetric cases require codes from chapter 11, codes in the range 630-679, Complications of Pregnancy, Childbirth, and the Puerperium. Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code V22.2 should be used in place of any chapter 11 codes. It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

2) Chapter 11 codes used only on the maternal record

Chapter 11 codes are to be used only on the maternal record, never on the record of the newborn.

3) Chapter 11 fifth-digits

Categories 640-64**9**, 651-676 have required fifth-digits, which indicate whether the encounter is antepartum, postpartum and whether a delivery has also occurred.

4) Fifth-digits, appropriate for each code

The fifth-digits, which are appropriate for each code number, are listed in brackets under each code. The fifth-digits on each code should all be consistent with each other. That is, should a delivery occur all of the fifth-digits should indicate the delivery.

b. Selection of OB Principal or First-listed Diagnosis

1) Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present codes V22.0, Supervision of normal first pregnancy, and V22.1, Supervision of other normal pregnancy, should be used as the first-listed diagnoses. These codes should not be used in conjunction with chapter 11 codes.

2) Prenatal outpatient visits for high-risk patients

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category V23, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 11 codes may be used in conjunction with these codes if appropriate.

3) Episodes when no delivery occurs

In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy, which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.

4) When a delivery occurs

When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should be the condition established after study that was responsible for the patient's admission. If the patient was admitted with a condition that resulted in the performance of a cesarean procedure, that condition should be selected as the principal diagnosis. If the reason for the admission/encounter was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission/encounter should be selected as the principal diagnosis, even if a cesarean was performed.

5) Outcome of delivery

An outcome of delivery code, V27.0-V27.9, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

c. Fetal Conditions Affecting the Management of the Mother

1) Codes from categories 655 and 656

Codes from categories 655, Known or suspected fetal abnormality affecting management of the mother, and 656, Other known or suspected fetal and placental problems affecting the management of the mother, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of

pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

See I.C.18.d. for suspected maternal and fetal conditions not found

2) In utero surgery

In cases when surgery is performed on the fetus, a diagnosis code from category 655, Known or suspected fetal abnormalities affecting management of the mother, should be assigned identifying the fetal condition. Procedure code 75.36, Correction of fetal defect, should be assigned on the hospital inpatient record.

No code from Chapter 15, the perinatal codes, should be used on the mother's record to identify fetal conditions. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

d. HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis of 647.6X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es).

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of 647.6X and V08.

e. Current Conditions Complicating Pregnancy

Assign a code from subcategory 648.x for patients that have current conditions when the condition affects the management of the pregnancy, childbirth, or the puerperium. Use additional secondary codes from other chapters to identify the conditions, as appropriate.

f. Diabetes mellitus in pregnancy

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant women who are diabetic should be assigned code 648.0x, Diabetes mellitus complicating pregnancy, and a secondary code from category 250, Diabetes mellitus, or category 249, Secondary diabetes to identify the type of diabetes.

Code V58.67, Long-term (current) use of insulin, should also be assigned if the diabetes mellitus is being treated with insulin.

g. Gestational diabetes

Gestational diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes after the pregnancy. Gestational diabetes is coded to 648.8x, Abnormal glucose tolerance. Codes 648.0x and 648.8x should never be used together on the same record.

Code V58.67, Long-term (current) use of insulin, should also be assigned if the gestational diabetes is being treated with insulin.

h. Normal Delivery, Code 650

1) Normal delivery

Code 650 is for use in cases when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode. Code 650 is always a principal diagnosis. It is not to be used if any other code from chapter 11 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Additional codes from other chapters may be used with code 650 if they are not related to or are in any way complicating the pregnancy.

2) Normal delivery with resolved antepartum complication

Code 650 may be used if the patient had a complication at some point during her pregnancy, but the complication is not present at the time of the admission for delivery.

3) V27.0, Single liveborn, outcome of delivery

V27.0, Single liveborn, is the only outcome of delivery code appropriate for use with 650.

i. The Postpartum and Peripartum Periods

1) Postpartum and peripartum periods

The postpartum period begins immediately after delivery and continues for six weeks following delivery. The peripartum period is defined as the last month of pregnancy to five months postpartum.

2) Postpartum complication

A postpartum complication is any complication occurring within the six-week period.

3) Pregnancy-related complications after 6 week period

Chapter 11 codes may also be used to describe pregnancy-related complications after the six-week period should the provider document that a condition is pregnancy related.

4) Postpartum complications occurring during the same admission as delivery

Postpartum complications that occur during the same admission as the delivery are identified with a fifth digit of "2." Subsequent admissions/encounters for postpartum complications should be identified with a fifth digit of "4."

5) Admission for routine postpartum care following delivery outside hospital

When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code V24.0, Postpartum care and examination immediately after delivery, should be assigned as the principal diagnosis.

6) Admission following delivery outside hospital with postpartum conditions

A delivery diagnosis code should not be used for a woman who has delivered prior to admission to the hospital. Any postpartum conditions and/or postpartum procedures should be coded.

7) Puerperal sepsis

Code 670.2x, Puerperal sepsis, should be assigned with a secondary code to identify the causal organism (e.g., for a bacterial infection, assign a code from category 041, Bacterial infections in conditions classified elsewhere and of unspecified site). A code from category 038, Septicemia, should not be used for puerperal sepsis. Do not assign code 995.91, Sepsis, as code 670.2x describes the sepsis. If applicable, use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction.

j. Code 677, Late effect of complication of pregnancy

1) Code 677

Code 677, Late effect of complication of pregnancy, childbirth, and the puerperium is for use in those cases when an initial complication of a pregnancy develops a sequelae requiring care or treatment at a future date.

2) After the initial postpartum period

This code may be used at any time after the initial postpartum period.

3) Sequencing of Code 677

This code, like all late effect codes, is to be sequenced following the code describing the sequelae of the complication.

k. Abortions

1) Fifth-digits required for abortion categories

Fifth-digits are required for abortion categories 634-637. Fifth digit assignment is based on the status of the patient at the beginning (or start) of the encounter. Fifth-digit 1, incomplete, indicates that all of the products of conception have not been expelled from the uterus. Fifth-digit 2, complete, indicates that all products of conception have been expelled from the uterus.

2) Code from categories 640-649 and 651-659

A code from categories 640-64**9** and 651-659 may be used as additional codes with an abortion code to indicate the complication leading to the abortion.

Fifth digit 3 is assigned with codes from these categories when used with an abortion code because the other fifth digits will not apply. Codes from the 660-669 series are not to be used for complications of abortion.

3) Code 639 for complications

Code 639 is to be used for all complications following abortion. Code 639 cannot be assigned with codes from categories 634-638.

4) Abortion with Liveborn Fetus

When an attempted termination of pregnancy results in a liveborn fetus assign code 644.21, Early onset of delivery, with an appropriate code from category V27, Outcome of Delivery. The procedure code for the attempted termination of pregnancy should also be assigned.

5) Retained Products of Conception following an abortion

Subsequent admissions for retained products of conception following a spontaneous or legally induced abortion are assigned the appropriate code from category 634, Spontaneous abortion, or 635 Legally induced abortion, with a fifth digit of "1" (incomplete). This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion.

12. Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)

a. Pressure ulcer stage codes

1) Pressure ulcer stages

Two codes are needed to completely describe a pressure ulcer: A code from subcategory 707.0, Pressure ulcer, to identify the site of the pressure ulcer and a code from subcategory 707.2, Pressure ulcer stages.

The codes in subcategory 707.2, Pressure ulcer stages, are to be used as an additional diagnosis with a code(s) from subcategory 707.0, Pressure Ulcer. Codes from 707.2, Pressure ulcer stages, may not be assigned as a principal or first-listed diagnosis. The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g., stasis ulcer).

The ICD-9-CM classifies pressure ulcer stages based on severity, which is designated by stages I-IV and unstageable.

2) Unstageable pressure ulcers

Assignment of code 707.25, Pressure ulcer, unstageable, should be based on the clinical documentation. Code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with code 707.20, Pressure ulcer, stage unspecified. Code 707.20 should be assigned when there is no documentation regarding the stage of the pressure ulcer.

3) Documented pressure ulcer stage

Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the

terms found in the index. For clinical terms describing the stage that are not found in the index, and there is no documentation of the stage, the provider should be queried.

4) Bilateral pressure ulcers with same stage

When a patient has bilateral pressure ulcers (e.g., both buttocks) and both pressure ulcers are documented as being the same stage, only the code for the site and one code for the stage should be reported.

5) Bilateral pressure ulcers with different stages

When a patient has bilateral pressure ulcers at the same site (e.g., both buttocks) and each pressure ulcer is documented as being at a different stage, assign one code for the site and the appropriate codes for the pressure ulcer stage.

6) Multiple pressure ulcers of different sites and stages

When a patient has multiple pressure ulcers at different sites (e.g., buttock, heel, shoulder) and each pressure ulcer is documented as being at different stages (e.g., stage 3 and stage 4), assign the appropriate codes for each different site and a code for each different pressure ulcer stage.

7) Patients admitted with pressure ulcers documented as healed

No code is assigned if the documentation states that the pressure ulcer is completely healed.

8) Patients admitted with pressure ulcers documented as healing

Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign code 707.20, Pressure ulcer stage, unspecified.

If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.

9) Patient admitted with pressure ulcer evolving into another stage during the admission

If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for highest stage reported for that site.

13. Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)

a. Coding of Pathologic Fractures

1) Acute Fractures vs. Aftercare

Pathologic fractures are reported using subcategory 733.1, when the fracture is newly diagnosed. Subcategory 733.1 may be used while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and treatment by a new physician.

Fractures are coded using the aftercare codes (subcategories V54.0, V54.2, V54.8 or V54.9) for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate codes.

See Section I. C. 17.b for information on the coding of traumatic fractures.

14. Chapter 14: Congenital Anomalies (740-759)

a. Codes in categories 740-759, Congenital Anomalies

Assign an appropriate code(s) from categories 740-759, Congenital Anomalies, when an anomaly is documented. A congenital anomaly may be the principal/first listed diagnosis on a record or a secondary diagnosis.

When a congenital anomaly does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

When the code assignment specifically identifies the congenital anomaly, manifestations that are an inherent component of the anomaly should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.

Codes from Chapter 14 may be used throughout the life of the patient. If a congenital anomaly has been corrected, a personal history code should be used to identify the history of the anomaly. Although present at birth, a congenital anomaly may not be identified until later in life. Whenever the condition is diagnosed by the physician, it is appropriate to assign a code from codes 740-759.

For the birth admission, the appropriate code from category V30, Liveborn infants, according to type of birth should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, 740-759.

15. Chapter 15: Newborn (Perinatal) Guidelines (760-779)

For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth. The following guidelines are provided for reporting purposes. Hospitals may record other diagnoses as needed for internal data use.

a. General Perinatal Rules

1) Chapter 15 Codes

They are never for use on the maternal record. Codes from Chapter 11, the obstetric chapter, are never permitted on the newborn record. Chapter 15 code may be used throughout the life of the patient if the condition is still present.

2) Sequencing of perinatal codes

Generally, codes from Chapter 15 should be sequenced as the principal/first-listed diagnosis on the newborn record, with the exception of the appropriate V30 code for the birth episode, followed by codes from any other chapter that provide additional detail. The "use additional code" note at the beginning of the chapter supports this guideline. If the index does not provide a specific code for a perinatal condition, assign code 779.89, Other specified conditions originating in the perinatal period, followed by the code from another chapter that specifies the condition. Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established.

3) Birth process or community acquired conditions

If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 15 should be used. If the condition is community-acquired, a code from Chapter 15 should not be assigned.

4) Code all clinically significant conditions

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring; or
- has implications for future health care needs

Note: The perinatal guidelines listed above are the same as the general coding guidelines for "additional diagnoses", except for the final point regarding implications for future health care needs. Codes should be assigned for conditions that have been specified by the provider as having implications for future health care needs. Codes from the perinatal chapter should not be assigned unless the provider has established a definitive diagnosis.

b. Use of codes V30-V39

When coding the birth of an infant, assign a code from categories V30-V39, according to the type of birth. A code from this series is assigned as a principal diagnosis, and assigned only once to a newborn at the time of birth.

c. Newborn transfers

If the newborn is transferred to another institution, the V30 series is not used at the receiving hospital.

d. Use of category V29

1) Assigning a code from category V29

Assign a code from category V29, Observation and evaluation of newborns and infants for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category V29 when the patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom.

A code from category V29 may also be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. Codes from category V29 are for use only for healthy newborns and infants for which no condition after study is found to be present.

2) V29 code on a birth record

A V29 code is to be used as a secondary code after the V30, Outcome of delivery, code.

e. Use of other V codes on perinatal records

V codes other than V30 and V29 may be assigned on a perinatal or newborn record code. The codes may be used as a principal or first-listed diagnosis for specific types of encounters or for readmissions or encounters when the V30 code no longer applies.

See Section I.C.18 for information regarding the assignment of V codes.

f. Maternal Causes of Perinatal Morbidity

Codes from categories 760-763, Maternal causes of perinatal morbidity and mortality, are assigned only when the maternal condition has actually affected the fetus or newborn. The fact that the mother has an associated medical condition or experiences some complication of pregnancy, labor or delivery does not justify the routine assignment of codes from these categories to the newborn record.

g. Congenital Anomalies in Newborns

For the birth admission, the appropriate code from category V30, Liveborn infants according to type of birth, should be used, followed by any congenital anomaly codes, categories 740-759. Use additional secondary codes from other chapters to specify conditions associated with the anomaly, if applicable.
Also, see Section I.C.14 for information on the coding of congenital anomalies.

h. Coding Additional Perinatal Diagnoses

1) Assigning codes for conditions that require treatment

Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.

2) Codes for conditions specified as having implications for future health care needs

Assign codes for conditions that have been specified by the provider as having implications for future health care needs.

Note: This guideline should not be used for adult patients.

3) Codes for newborn conditions originating in the perinatal period

Assign a code for newborn conditions originating in the perinatal period (categories 760-779), as well as complications arising during the current episode of care classified in other chapters, only if the diagnoses have been documented by the responsible provider at the time of transfer or discharge as having affected the fetus or newborn.

i. Prematurity and Fetal Growth Retardation

Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. The 5th digit assignment for codes from category 764 and subcategories 765.0 and 765.1 should be based on the recorded birth weight and estimated gestational age.

A code from subcategory 765.2, Weeks of gestation, should be assigned as an additional code with category 764 and codes from 765.0 and 765.1 to specify weeks of gestation as documented by the provider in the record.

j. Newborn sepsis

Code 771.81, Septicemia [sepsis] of newborn, should be assigned with a secondary code from category 041, Bacterial infections in conditions classified elsewhere and of unspecified site, to identify the organism. A code from category 038, Septicemia, should not be used on a newborn record. Do not assign code 995.91, Sepsis, as code 771.81 describes the sepsis. If applicable, use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction.

16. Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)

Reserved for future guideline expansion

17. Chapter 17: Injury and Poisoning (800-999)

a. Coding of Injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-9-CM, but should not be assigned unless information for a more specific code is not available. These traumatic injury codes are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

1) Superficial injuries

Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

2) Primary injury with damage to nerves/blood vessels

When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) from categories 950-957, Injury to nerves and spinal cord, and/or 900-904, Injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

b. Coding of Traumatic Fractures

The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories 800-829 and the level of detail furnished by medical record content. Combination categories for multiple fractures are provided for use when there is insufficient detail in the medical record (such as trauma cases transferred to another hospital), when the reporting form limits the number of codes that can be used in reporting pertinent clinical data, or when there is insufficient specificity at the fourth-digit or fifth-digit level. More specific guidelines are as follows:

1) Acute Fractures vs. Aftercare

Traumatic fractures are coded using the acute fracture codes (800-829) while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

Fractures are coded using the aftercare codes (subcategories V54.0, V54.1, V54.8, or V54.9) for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate codes.

Pathologic fractures are not coded in the 800-829 range, but instead are assigned to subcategory 733.1. *See Section I.C.13.a for additional information.*

2) Multiple fractures of same limb

Multiple fractures of same limb classifiable to the same three-digit or four-digit category are coded to that category.

3) Multiple unilateral or bilateral fractures of same bone

Multiple unilateral or bilateral fractures of same bone(s) but classified to different fourth-digit subdivisions (bone part) within the same three-digit category are coded individually by site.

4) Multiple fracture categories 819 and 828

Multiple fracture categories 819 and 828 classify bilateral fractures of both upper limbs (819) and both lower limbs (828), but without any detail at the fourth-digit level other than open and closed type of fractures.

5) Multiple fractures sequencing

Multiple fractures are sequenced in accordance with the severity of the fracture. The provider should be asked to list the fracture diagnoses in the order of severity.

c. Coding of Burns

Current burns (940-948) are classified by depth, extent and by agent (E code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement).

1) Sequencing of burn and related condition codes

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.

b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.

c. When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.

2) Burns of the same local site

Classify burns of the same local site (three-digit category level, 940-947) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

3) Non-healing burns

Non-healing burns are coded as acute burns.
Necrosis of burned skin should be coded as a non-healed burn.

4) Code 958.3, Posttraumatic wound infection

Assign code 958.3, Posttraumatic wound infection, not elsewhere classified, as an additional code for any documented infected burn site.

5) Assign separate codes for each burn site

When coding burns, assign separate codes for each burn site. Category 946 Burns of Multiple specified sites, should only be used if the location of the burns are not documented. Category 949, Burn, unspecified, is extremely vague and should rarely be used.

6) Assign codes from category 948, Burns

Burns classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category 948 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category 948 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.

In assigning a code from category 948:

Fourth-digit codes are used to identify the percentage of total body surface involved in a burn (all degree).

Fifth-digits are assigned to identify the percentage of body surface involved in third-degree burn.

Fifth-digit zero (0) is assigned when less than 10 percent or when no body surface is involved in a third-degree burn.

Category 948 is based on the classic "rule of nines" in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults and patients who have large buttocks, thighs, or abdomen that involve burns.

7) Encounters for treatment of late effects of burns

Encounters for the treatment of the late effects of burns (i.e., scars or joint contractures) should be coded to the residual condition (sequelae) followed by the appropriate late effect code (906.5-906.9). A late effect E code may also be used, if desired.

8) Sequelae with a late effect code and current burn

When appropriate, both a sequelae with a late effect code, and a current burn code may be assigned on the same record (when both a current burn and sequelae of an old burn exist).

d. Coding of Debridement of Wound, Infection, or Burn

Excisional debridement involves surgical removal or cutting away, as opposed to a mechanical (brushing, scrubbing, washing) debridement.

For coding purposes, excisional debridement is assigned to code 86.22.

Nonexcisional debridement is assigned to code 86.28.

e. Adverse Effects, Poisoning and Toxic Effects

The properties of certain drugs, medicinal and biological substances or combinations of such substances, may cause toxic reactions. The occurrence of drug toxicity is classified in ICD-9-CM as follows:

1) Adverse Effect

When the drug was correctly prescribed and properly administered, code the reaction plus the appropriate code from the E930-E949 series. Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is

coded and followed by the appropriate code from the E930-E949 series.

Adverse effects of therapeutic substances correctly prescribed and properly administered (toxicity, synergistic reaction, side effect, and idiosyncratic reaction) may be due to (1) differences among patients, such as age, sex, disease, and genetic factors, and (2) drug-related factors, such as type of drug, route of administration, duration of therapy, dosage, and bioavailability.

2) Poisoning

(a) **Error was made in drug prescription**

Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person, use the appropriate poisoning code from the 960-979 series.

(b) **Overdose of a drug intentionally taken**

If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning (960-979 series).

(c) **Nonprescribed drug taken with correctly prescribed and properly administered drug**

If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.

(d) **Interaction of drug(s) and alcohol**

When a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

(e) **Sequencing of poisoning**

When coding a poisoning or reaction to the improper use of a medication (e.g., wrong dose, wrong substance, wrong route of administration) the poisoning code is sequenced first, followed by a code for the manifestation. If there is also a diagnosis of drug abuse or dependence to the substance, the abuse or dependence is coded as an additional code.
See Section I.C.3.a.6.b. if poisoning is the result of insulin pump malfunctions and Section I.C.19 for general use of E-codes.

3) Toxic Effects

(a) **Toxic effect codes**

When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories 980-989.

(b) **Sequencing toxic effect codes**

A toxic effect code should be sequenced first, followed by the code(s) that identify the result of the toxic effect.

(c) **External cause codes for toxic effects**

An external cause code from categories E860-E869 for accidental exposure, codes E950.6 or E950.7 for intentional self-harm, category E962 for assault, or categories E980-E982, for undetermined, should also be assigned to indicate intent.

f. Complications of care

1) General guidelines for complications of care

(a) **Documentation of complications of care**

See Section I.B.18. for information on documentation of complications of care.

(b) **Use additional code to identify nature of complication**

An additional code identifying the complication should be assigned with codes in categories 996-999, Complications of Surgical and Medical Care NEC, when the additional code provides greater specificity as to the nature of the condition. If the complication code fully describes the condition, no additional code is necessary.

2) Transplant complications

(a) **Transplant complications other than kidney**

Codes under subcategory 996.8, Complications of transplanted organ, are for use for both complications and rejection of transplanted organs. A transplant complication code is only assigned if the complication affects the function of the transplanted organ. Two codes are required to fully describe a transplant complication, the appropriate code from subcategory

996.8 and a secondary code that identifies the complication.

Pre-existing conditions or conditions that develop after the transplant are not coded as complications unless they affect the function of the transplanted organs.

See I.C.18.d.3) for transplant organ removal status

See I.C.2.i for malignant neoplasm associated with transplanted organ.

(b) **Kidney transplant complications**

Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Code 996.81 should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication. Code 996.81 should not be assigned for post kidney transplant patients who have chronic kidney (CKD) unless a transplant complication such as transplant failure or rejection is documented. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

Conditions that affect the function of the transplanted kidney, other than CKD, should be assigned code 996.81, Complications of transplanted organ, Kidney, and a secondary code that identifies the complication.

For patients with CKD following a kidney transplant, but who do not have a complication such as failure or rejection, *see section I.C.10.a.2, Chronic kidney disease and kidney transplant status*.

3) Ventilator associated pneumonia

(a) **Documentation of Ventilator associated Pneumonia**

As with all procedural or postprocedural complications, code assignment is based on the provider's documentation of the relationship between the condition and the procedure.

Code 997.31, Ventilator associated pneumonia, should be assigned only when the provider has documented

ventilator associated pneumonia (VAP). An additional code to identify the organism (e.g., Pseudomonas aeruginosa, code 041.7) should also be assigned. Do not assign an additional code from categories 480-484 to identify the type of pneumonia.

Code 997.31 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator but the provider has not specifically stated that the pneumonia is ventilator-associated pneumonia.

If the documentation is unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.

(b) **Patient admitted with pneumonia and develops VAP**

A patient may be admitted with one type of pneumonia (e.g., code 481, Pneumococcal pneumonia) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories 480-484 for the pneumonia diagnosed at the time of admission. Code 997.31, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

g. SIRS due to Non-infectious Process

The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code 995.93, Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome due to non-infectious process with acute organ dysfunction. If an acute organ dysfunction is documented, the appropriate code(s) for the associated acute organ dysfunction(s) should be assigned in addition to code 995.94. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

When the non-infectious condition has led to an infection that results in SIRS, *see Section I.C.1.b.12 for the guideline for sepsis and severe sepsis associated with a non-infectious process.*

18. Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V91)

Note: The chapter specific guidelines provide additional information about the use of V codes for specified encounters.

a. Introduction

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0 - V91.99) is provided to deal with occasions when circumstances other than a disease or injury (codes 001-999) are recorded as a diagnosis or problem.

There are four primary circumstances for the use of V codes:

1) A person who is not currently sick encounters the health services for some specific reason, such as to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on health related issues.

2) A person with a resolving disease or injury, or a chronic, long-term condition requiring continuous care, encounters the health care system for specific aftercare of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change). A diagnosis/symptom code should be used whenever a current, acute, diagnosis is being treated or a sign or symptom is being studied.

3) Circumstances or problems influence a person's health status but are not in themselves a current illness or injury.

4) Newborns, to indicate birth status

b. V codes use in any healthcare setting

V codes are for use in any healthcare setting. V codes may be used as either a first listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain V codes may only be used as first listed, others only as secondary codes.
See Section I.C.18.e, V Codes That May Only be Principal/First-Listed Diagnosis.

c. V Codes indicate a reason for an encounter

They are not procedure codes. A corresponding procedure code must accompany a V code to describe the procedure performed.

d. Categories of V Codes

1) Contact/Exposure

Category V01 indicates contact with or exposure to communicable diseases. These codes are for patients who do not show any sign or symptom of a disease but have been exposed to it by close personal contact with an infected individual or are in an area where a disease is epidemic. These codes may be used as a first listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

Codes V15.84 – V15.86 describe contact with or (suspected) exposure to asbestos, potentially hazardous body fluids, and lead.

Subcategories V87.0 – V87.3 describe contact with or (suspected) exposure to hazardous metals, aromatic compounds, other potentially hazardous chemicals, and other potentially hazardous substances.

2) Inoculations and vaccinations

Categories V03-V06 are for encounters for inoculations and vaccinations. They indicate that a patient is being seen to receive a prophylactic inoculation against a disease. The injection itself must be represented by the appropriate procedure code. A code from V03-V06 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3) Status

Status codes indicate that a patient is a carrier of a disease, has the sequelae or residual of a past disease or condition, or has another factor influencing a person's health status. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code V42.1, Heart transplant status, should not be used with code 996.83, Complications of transplanted heart. The status code does not provide additional information. The

complication code indicates that the patient is a heart transplant patient.

The status V codes/categories are:

V02	Carrier or suspected carrier of infectious diseases Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.
V07.5X	Use of agents affecting estrogen receptors and estrogen level This code indicates when a patient is receiving a drug that affects estrogen receptors and estrogen levels for prevention of cancer.
V08	Asymptomatic HIV infection status This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.
V09	Infection with drug-resistant microorganisms This category indicates that a patient has an infection that is resistant to drug treatment. Sequence the infection code first.
V21	Constitutional states in development
V22.2	Pregnant state, incidental This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.
V26.5x	Sterilization status
V42	Organ or tissue replaced by transplant
V43	Organ or tissue replaced by other means
V44	Artificial opening status
V45	Other postsurgical states Assign code V45.87, Transplant organ removal status, to indicate that a transplanted organ has been previously removed. This code should not be assigned for the encounter in which the transplanted organ is removed. The complication necessitating removal of the transplant organ should be assigned for that encounter. *See section I.C17.f.2. for information on the coding of organ transplant complications.* Assign code V45.88, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to the current facility, as a secondary diagnosis when a patient is received by

transfer into a facility and documentation indicates they were administered tissue plasminogen activator (tPA) within the last 24 hours prior to admission to the current facility.

This guideline applies even if the patient is still receiving the tPA at the time they are received into the current facility.

The appropriate code for the condition for which the tPA was administered (such as cerebrovascular disease or myocardial infarction) should be assigned first.

Code V45.88 is only applicable to the receiving facility record and not to the transferring facility record.

V46 Other dependence on machines
V49.6 Upper limb amputation status
V49.7 Lower limb amputation status
Note: Categories V42-V46, and subcategories V49.6, V49.7 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.
V49.81 Asymptomatic postmenopausal status (age-related) (natural)
V49.82 Dental sealant status
V49.83 Awaiting organ transplant status
V49.86 Do not resuscitate status
This code may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay.
V49.87 Physical restraint status
This code may be used when it is documented by the provider that a patient has been put in restraints during the current encounter. Please note that this code should not be reported when it is documented by the provider that a patient is temporarily restrained during a procedure.
V58.6x Long-term (current) drug use
Codes from this subcategory indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. This subcategory is not for use of

medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug dependence instead.

Assign a code from subcategory V58.6, Long-term (current) drug use, if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from subcategory V58.6 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis).

V83 Genetic carrier status

Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease.

V84 Genetic susceptibility status

Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

Codes from category V84, Genetic susceptibility to disease, should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling associated with procreative management, a code from subcategory V26.3, Genetic counseling and testing, should be assigned as the first-listed code, followed by a code from category V84. Additional codes should be assigned for any applicable family or personal history.

See Section I.C. 18.d.14 for information on prophylactic organ removal due to a genetic susceptibility.

V85 Body Mass Index (BMI)
V86 Estrogen receptor status
V88 Acquired absence of other organs and tissue
V90 Retained foreign body

4) History (of)

There are two types of history V codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring. The exceptions to this general rule are category V14, Personal history of allergy to medicinal agents, and subcategory V15.0, Allergy, other than to medicinal agents. A person who has had an allergic episode to a substance or food in the past should always be considered allergic to the substance.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The history V code categories are:

V10 Personal history of malignant neoplasm
V12 Personal history of certain other diseases
V13 Personal history of other diseases
Except: V13.4, Personal history of arthritis, and subcategory V13.6, Personal history of congenital (corrected) malformations. These conditions are life-long so are not true history codes.
V14 Personal history of allergy to medicinal agents
V15 Other personal history presenting hazards to health
Except: **Codes** V15.7, Personal history of contraception**; V15.84, Contact with and (suspected) exposure to asbestos; V15.85, Contact with and (suspected) exposure to**

potentially hazardous body fluids; V15.86, Contact with and (suspected) exposure to lead.

V16 Family history of malignant neoplasm
V17 Family history of certain chronic disabling diseases
V18 Family history of certain other specific diseases
V19 Family history of other conditions
V87 Other specified personal exposures and history presenting hazards to health

Except: Subcategories V87.0, Contact with and (suspected) exposure to hazardous metals; V87.1, Contact with and (suspected) exposure to hazardous aromatic compounds; V87.2, Contact with and (suspected) exposure to other potentially hazardous chemicals; and V87.3, Contact with and (suspected) exposure to other potentially hazardous substances

5) Screening

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease. Screenings that are recommended for many subgroups in a population include: routine mammograms for women over 40, a fecal occult blood test for everyone over 50, an amniocentesis to rule out a fetal anomaly for pregnant women over 35, because the incidence of breast cancer and colon cancer in these subgroups is higher than in the general population, as is the incidence of Down's syndrome in older mothers.

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

The V code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening V code categories:
V28 Antenatal screening
V73-V82 Special screening examinations

6) Observation

There are three observation V code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out. The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding E code to identify any external cause.

The observation codes are to be used as principal diagnosis only. The only exception to this is when the principal diagnosis is required to be a code from the V30, Live born infant, category. Then the V29 observation code is sequenced after the V30 code. Additional codes may be used in addition to the observation code but only if they are unrelated to the suspected condition being observed.

Codes from subcategory V89.0, Suspected maternal and fetal conditions not found, may either be used as a first listed or as an additional code assignment depending on the case. They are for use in very limited circumstances on a maternal record when an encounter is for a suspected maternal or fetal condition that is ruled out during that encounter (for example, a maternal or fetal condition may be suspected due to an abnormal test result). These codes should not be used when the condition is confirmed. In those cases, the confirmed condition should be coded. In addition, these codes are not for use if an illness or any signs or symptoms related to the suspected condition or problem are present. In such cases the diagnosis/symptom code is used.

Additional codes may be used in addition to the code from subcategory V89.0, but only if they are unrelated to the suspected condition being evaluated.

Codes from subcategory V89.0 may not be used for encounters for antenatal screening of mother. *See Section I.C.18.d., Screening).*

For encounters for suspected fetal condition that are inconclusive following testing and evaluation, assign the appropriate code from category 655, 656, 657 or 658.

The observation V code categories:

V29	Observation and evaluation of newborns for suspected condition not found For the birth encounter, a code from category V30 should be sequenced before the V29 code.
V71	Observation and evaluation for suspected condition not found
V89	Suspected maternal and fetal conditions not found

7) Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare V code should not be used if treatment is directed at a current, acute disease or injury. The diagnosis code is to be used in these cases. Exceptions to this rule are codes V58.0, Radiotherapy, and codes from subcategory V58.1, Encounter for chemotherapy and immunotherapy for neoplastic conditions. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy or chemotherapy for the treatment of a neoplasm. Should a patient receive both chemotherapy and radiation therapy during the same encounter code V58.0 and V58.1 may be used together on a record with either one being sequenced first.

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Aftercare codes should be used in conjunction with any other aftercare codes or other diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes is discretionary.

Certain aftercare V code categories need a secondary diagnosis code to describe the resolving condition or sequelae, for others, the condition is inherent in the code title.

Additional V code aftercare category terms include fitting and adjustment, and attention to artificial openings.

Status V codes may be used with aftercare V codes to indicate the nature of the aftercare. For example code V45.81, Aortocoronary bypass status, may be used with code V58.73, Aftercare following surgery of the circulatory system, NEC, to indicate the surgery for which the aftercare is being performed. Also, a transplant status code may be used following code V58.44, Aftercare following organ transplant, to identify the organ transplanted. A status code should not be used when the aftercare code indicates the type of status, such as using V55.0, Attention to tracheostomy with V44.0, Tracheostomy status.

See Section I. B.16 Admissions/Encounter for Rehabilitation

The aftercare V category/codes:

V51.0	Encounter for breast reconstruction following mastectomy
V52	Fitting and adjustment of prosthetic device and implant
V53	Fitting and adjustment of other device
V54	Other orthopedic aftercare
V55	Attention to artificial openings
V56	Encounter for dialysis and dialysis catheter care
V57	Care involving the use of rehabilitation procedures
V58.0	Radiotherapy
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V58.3x	Attention to dressings and sutures
V58.41	Encounter for planned post-operative wound closure
V58.42	Aftercare, surgery, neoplasm
V58.43	Aftercare, surgery, trauma
V58.44	Aftercare involving organ transplant
V58.49	Other specified aftercare following surgery
V58.7x	Aftercare following surgery
V58.81	Fitting and adjustment of vascular catheter
V58.82	Fitting and adjustment of non-vascular catheter
V58.83	Monitoring therapeutic drug
V58.89	Other specified aftercare

8) Follow-up

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes that explain current treatment for a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

A follow-up code may be used to explain repeated visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code should be used in place of the follow-up code.

The follow-up V code categories:

V24	Postpartum care and evaluation
V67	Follow-up examination

9) Donor

Category V59 is the donor codes. They are used for living individuals who are donating blood or other body tissue. These codes are only for individuals donating for others, not for self donations. They are not for use to identify cadaveric donations.

10) Counseling

Counseling V codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems. They are not necessary for use in conjunction with a diagnosis code when the counseling component of care is considered integral to standard treatment.

The counseling V categories/codes:

V25.0	General counseling and advice for contraceptive management
V26.3	Genetic counseling
V26.4	General counseling and advice for procreative management
V61.X	Other family circumstances
V65.1	Person consulted on behalf of another person
V65.3	Dietary surveillance and counseling
V65.4	Other counseling, not elsewhere classified

11) Obstetrics and related conditions

See Section I.C.11., the Obstetrics guidelines for further instruction on the use of these codes.

V codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes V22.0, Supervision of normal first pregnancy, and V22.1, Supervision of other normal pregnancy, are always first listed and are not to be used with any other code from the OB chapter.

The outcome of delivery, category V27, should be included on all maternal delivery records. It is always a secondary code.

V codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

Obstetrics and related conditions V code categories:

V22	Normal pregnancy
V23	Supervision of high-risk pregnancy Except: V23.2, Pregnancy with history of abortion. Code 646.3, Recurrent pregnancy loss, from the OB chapter is required to indicate a history of abortion during a pregnancy.
V24	Postpartum care and evaluation
V25	Encounter for contraceptive management Except V25.0x *(See Section I.C.18.d.11, Counseling)*
V26	Procreative management Except V26.5x, Sterilization status, V26.3 and V26.4 *(See Section I.C.18.d.11., Counseling)*
V27	Outcome of delivery
V28	Antenatal screening *(See Section I.C.18.d.6., Screening)*
V91	Multiple gestation placenta status

12) Newborn, infant and child

See Section I.C.15, the Newborn guidelines for further instruction on the use of these codes.

Newborn V code categories:

V20	Health supervision of infant or child
V29	Observation and evaluation of newborns for suspected condition not found

(See Section I.C.18.d.7, Observation)

V30-V39 Liveborn infant according to type of birth

13) Routine and administrative examinations

The V codes allow for the description of encounters for routine examinations, such as, a general check-up, or examinations for administrative purposes, such as a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.

Pre-operative examination and pre-procedural laboratory examination V codes are for use only in those situations when a patient is being cleared for a procedure or surgery and no treatment is given.

The V codes categories/code for routine and administrative examinations:

V20.2 Routine infant or child health check
Any injections given should have a corresponding procedure code.

V70 General medical examination

V72 Special investigations and examinations
Codes V72.5 and V72.62 may be used if the reason for the patient encounter is for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

14) Miscellaneous V codes

The miscellaneous V codes capture a number of other health care encounters that do not fall into one of the other categories. Certain of these codes identify the reason for the encounter, others are for use as additional codes that provide useful information on circumstances that may affect a patient's care and treatment.

Prophylactic Organ Removal

For encounters specifically for prophylactic removal of breasts, ovaries, or another organ due to a genetic susceptibility to cancer or a family history of cancer, the principal or first listed code should be a code from subcategory V50.4, Prophylactic organ removal, followed by the appropriate genetic susceptibility code and the appropriate family history code.

If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory V50.4. A V50.4 code should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.

Miscellaneous V code categories/codes:

V07	Need for isolation and other prophylactic or treatment measures Except V07.5X, Use of agents affecting estrogen receptors and estrogen levels
V40.31	**Wandering in diseases classified elsewhere**
V50	Elective surgery for purposes other than remedying health states
V58.5	Orthodontics
V60	Housing, household, and economic circumstances
V62	Other psychosocial circumstances
V63	Unavailability of other medical facilities for care
V64	Persons encountering health services for specific procedures, not carried out
V66	Convalescence and Palliative Care
V68	Encounters for administrative purposes
V69	Problems related to lifestyle

15) Nonspecific V codes

Certain V codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient setting should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

Nonspecific V code categories/codes:

V11	Personal history of mental disorder

A code from the mental disorders chapter, with an in remission fifth-digit, should be used.

V13.4 Personal history of arthritis
V13.6 Personal history of congenital malformations
V15.7 Personal history of contraception
V23.2 Pregnancy with history of abortion

V40 Mental and behavioral problems
Exception:
V40.31 Wandering in diseases classified elsewhere
V41 Problems with special senses and other special functions
V47 Other problems with internal organs
V48 Problems with head, neck, and trunk
V49 Problems with limbs and other problems

Exceptions:

V49.6	Upper limb amputation status
V49.7	Lower limb amputation status
V49.81	Asymptomatic postmenopausal status (age-related) (natural)
V49.82	Dental sealant status
V49.83	Awaiting organ transplant status
V49.86	Do not resuscitate status
V49.87	Physical restraints status

V51.8 Other aftercare involving the use of plastic surgery
V58.2 Blood transfusion, without reported diagnosis
V58.9 Unspecified aftercare
See Section IV.K. and Section IV.L. of the Outpatient guidelines.

e. V Codes That May Only be Principal/First-Listed Diagnosis

The list of V codes/categories below may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined or when there is more than one V code that meets the definition of principal diagnosis (e.g., a patient is admitted to home healthcare for both aftercare and rehabilitation and they equally meet the definition of principal diagnosis). These codes should not be reported if they do not meet the definition of principal or first-listed diagnosis.

See Section II and Section IV.A for information on selection of principal and first-listed diagnosis.

See Section II.C for information on two or more diagnoses that equally meet the definition for principal diagnosis.

V20.X Health supervision of infant or child
V22.0 Supervision of normal first pregnancy
V22.1 Supervision of other normal pregnancy
V24.X Postpartum care and examination
V26.81 Encounter for assisted reproductive fertility procedure cycle
V26.82 Encounter for fertility preservation procedure
V30.X Single liveborn
V31.X Twin, mate liveborn
V32.X Twin, mate stillborn
V33.X Twin, unspecified
V34.X Other multiple, mates all liveborn
V35.X Other multiple, mates all stillborn
V36.X Other multiple, mates live- and stillborn
V37.X Other multiple, unspecified
V39.X Unspecified
V46.12 Encounter for respirator dependence during power failure
V46.13 Encounter for weaning from respirator [ventilator]
V51.0 Encounter for breast reconstruction following mastectomy
V56.0 Extracorporeal dialysis
V57.X Care involving use of rehabilitation procedures
V58.0 Radiotherapy
V58.11 Encounter for antineoplastic chemotherapy
V58.12 Encounter for antineoplastic immunotherapy
V59.X Donors
V66.0 Convalescence and palliative care following surgery
V66.1 Convalescence and palliative care following radiotherapy
V66.2 Convalescence and palliative care following chemotherapy
V66.3 Convalescence and palliative care following psychotherapy and other treatment for mental disorder
V66.4 Convalescence and palliative care following treatment of fracture
V66.5 Convalescence and palliative care following other treatment
V66.6 Convalescence and palliative care following combined treatment
V66.9 Unspecified convalescence
V68.X Encounters for administrative purposes
V70.0 Routine general medical examination at a health care facility
V70.1 General psychiatric examination, requested by the authority
V70.2 General psychiatric examination, other and unspecified
V70.3 Other medical examination for administrative purposes
V70.4 Examination for medicolegal reasons
V70.5 Health examination of defined subpopulations

V70.6 Health examination in population surveys
V70.8 Other specified general medical examinations
V70.9 Unspecified general medical examination
V71.X Observation and evaluation for suspected conditions not found

19. Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Introduction: These guidelines are provided for those who are currently collecting E codes in order that there will be standardization in the process. If your institution plans to begin collecting E codes, these guidelines are to be applied. The use of E codes is supplemental to the application of ICD-9-CM diagnosis codes.

External causes of injury and poisoning codes (categories E000 and E800-E999) are intended to provide data for injury research and evaluation of injury prevention strategies. Activity codes (categories E001-E030) are intended to be used to describe the activity of a person seeking care for injuries as well as other health conditions, when the injury or other health condition resulted from an activity or the activity contributed to a condition. E codes capture how the injury, poisoning, or adverse effect happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the person's status (e.g. civilian, military), the associated activity and the place where the event occurred.

Some major categories of E codes include:

transport accidents
poisoning and adverse effects of drugs, medicinal substances and biologicals
accidental falls
accidents caused by fire and flames
accidents due to natural and environmental factors
late effects of accidents, assaults or self injury
assaults or purposely inflicted injury
suicide or self inflicted injury

These guidelines apply for the coding and collection of E codes from records in hospitals, outpatient clinics, emergency departments, other ambulatory care settings and provider offices, and nonacute care settings, except when other specific guidelines apply.

a. General E Code Coding Guidelines

1) Used with any code in the range of 001-V91

An E code from categories E800-E999 may be used with any code in the range of 001-V91, which indicates an injury, poisoning, or adverse effect due to an external cause.

An activity E code (categories E001-E030) may be used with any code in the range of 001-V91 that indicates an injury, or other health condition that resulted from an activity, or the activity contributed to a condition.

2) Assign the appropriate E code for all initial treatments

Assign the appropriate E code for the initial encounter of an injury, poisoning, or adverse effect of drugs, not for subsequent treatment.

External cause of injury codes (E-codes) may be assigned while the acute fracture codes are still applicable.
See Section I.C.17.b.1 for coding of acute fractures.

3) Use the full range of E codes

Use the full range of E codes (E800 – E999) to completely describe the cause, the intent and the place of occurrence, if applicable, for all injuries, poisonings, and adverse effects of drugs.

See a.1.), j.), and k.) in this section for information on the use of status and activity E codes.

4) Assign as many E codes as necessary

Assign as many E codes as necessary to fully explain each cause.

5) The selection of the appropriate E code

The selection of the appropriate E code is guided by the Index to External Causes, which is located after the alphabetical index to diseases and by Inclusion and Exclusion notes in the Tabular List.

6) E code can never be a principal diagnosis

An E code can never be a principal (first listed) diagnosis.

External cause code(s) with systemic inflammatory response syndrome (SIRS)

An external cause code is not appropriate with a code from subcategory 995.9, unless the patient also has another condition for which an E code would be appropriate (such as an injury, poisoning, or adverse effect of drugs.

7) Multiple Cause E Code Coding Guidelines

More than one E-code is required to fully describe the external cause of an illness, injury or poisoning. The assignment of E-codes should be sequenced in the following priority:

If two or more events cause separate injuries, an E code should be assigned for each cause. The first listed E code will be selected in the following order:

E codes for child and adult abuse take priority over all other E codes.
See Section I.C.19.e., Child and Adult abuse guidelines.

E codes for terrorism events take priority over all other E codes except child and adult abuse.

E codes for cataclysmic events take priority over all other E codes except child and adult abuse and terrorism.

E codes for transport accidents take priority over all other E codes except cataclysmic events, child and adult abuse and terrorism.

Activity and external cause status codes are assigned following all causal (intent) E codes.

The first-listed E code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

8) If the reporting format limits the number of E codes

If the reporting format limits the number of E codes that can be used in reporting clinical data, report the code for the cause/intent most related to the principal diagnosis. If the format permits capture of additional E codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity or external status.

b. Place of Occurrence Guideline

Use an additional code from category E849 to indicate the Place of Occurrence. The Place of Occurrence describes the place where the event occurred and not the patient's activity at the time of the event.

Do not use E849.9 if the place of occurrence is not stated.

c. Adverse Effects of Drugs, Medicinal and Biological Substances Guidelines

1) Do not code directly from the Table of Drugs

Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.

2) Use as many codes as necessary to describe

Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.

If the reporting format limits the number of E codes, and there are different fourth digit codes in the same three digit category, use the code for "Other specified" of that category of drugs, medicinal or biological substances. If there is no "Other specified" code in that category, use the appropriate "Unspecified" code in that category.

If the reporting format limits the number of E codes, and the codes are in different three digit categories, assign the appropriate E code for other multiple drugs and medicinal substances.

3) If the same E code would describe the causative agent

If the same E code would describe the causative agent for more than one adverse reaction, assign the code only once.

4) If two or more drugs, medicinal or biological substances

If two or more drugs, medicinal or biological substances are reported, code each individually unless the combination code is listed in the Table of Drugs and Chemicals. In that case, assign the E code for the combination.

5) When a reaction results from the interaction of a drug(s)

When a reaction results from the interaction of a drug(s) and alcohol, use poisoning codes and E codes for both.

6) Codes from the E930-E949 series

Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930-E949 series.

d. Child and Adult Abuse Guideline

1) Intentional injury

When the cause of an injury or neglect is intentional child or adult abuse, the first listed E code should be assigned from categories E960-E968, Homicide and injury purposely inflicted by other persons, (except category E967). An E code from category E967, Child and adult battering and other maltreatment, should be added as an additional code to identify the perpetrator, if known.

2) Accidental intent

In cases of neglect when the intent is determined to be accidental E code E904.0, Abandonment or neglect of infant and helpless person, should be the first listed E code.

e. Unknown or Suspected Intent Guideline

1) If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is unknown

If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is unknown or unspecified, code the intent as undetermined E980-E989.

2) If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is questionable

If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is questionable, probable or suspected, code the intent as undetermined E980-E989.

f. Undetermined Cause

When the intent of an injury or poisoning is known, but the cause is unknown, use codes: E928.9, Unspecified accident, E958.9, Suicide and self-inflicted injury by unspecified means, and E968.9, Assault by unspecified means.

These E codes should rarely be used, as the documentation in the medical record, in both the inpatient outpatient and other settings, should normally provide sufficient detail to determine the cause of the injury.

g. Late Effects of External Cause Guidelines

1) Late effect E codes

Late effect E codes exist for injuries and poisonings but not for adverse effects of drugs, misadventures and surgical complications.

2) Late effect E codes (E929, E959, E969, E977, E989, or E999.1)

A late effect E code (E929, E959, E969, E977, E989, or E999.1) should be used with any report of a late effect or sequela resulting from a previous injury or poisoning (905-909).

3) Late effect E code with a related current injury

A late effect E code should never be used with a related current nature of injury code.

4) Use of late effect E codes for subsequent visits

Use a late effect E code for subsequent visits when a late effect of the initial injury or poisoning is being treated. There is no late effect E code for adverse effects of drugs.
Do not use a late effect E code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury or poisoning when no late effect of the injury has been documented.

h. Misadventures and Complications of Care Guidelines

1) Code range E870-E876

Assign a code in the range of E870-E876 if misadventures are stated by the provider. When applying the E code guidelines pertaining to sequencing, these E codes are considered causal codes.

2) Code range E878-E879

Assign a code in the range of E878-E879 if the provider attributes an abnormal reaction or later complication to a surgical or medical procedure, but does not mention misadventure at the time of the procedure as the cause of the reaction.

i. Terrorism Guidelines

1) Cause of injury identified by the Federal Government (FBI) as terrorism

When the cause of an injury is identified by the Federal Government (FBI) as terrorism, the first-listed E-code should be a code from category E979, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at E979. The terrorism E-code is the only E-code that should be assigned. Additional E codes from the assault categories should not be assigned.

2) Cause of an injury is suspected to be the result of terrorism

When the cause of an injury is suspected to be the result of terrorism a code from category E979 should not be assigned. Assign a code in the range of E codes based circumstances on the documentation of intent and mechanism.

3) Code E979.9, Terrorism, secondary effects

Assign code E979.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act.

4) Statistical tabulation of terrorism codes

For statistical purposes these codes will be tabulated within the category for assault, expanding the current category from E960-E969 to include E979 and E999.1.

j. Activity Code Guidelines

Assign a code from category E001-E030 to describe the activity that caused or contributed to the injury or other health condition.

Unlike other E codes, activity E codes may be assigned to indicate a health condition (not just injuries) resulted from an activity, or the activity contributed to the condition.

The activity codes are not applicable to poisonings, adverse effects, misadventures or late effects.

Do not assign E030, Unspecified activity, if the activity is not stated.

k. External cause status

A code from category E000, External cause status, should be assigned whenever any other E code is assigned for an encounter, including an Activity E code, except for the events noted below. Assign a code from category E000, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event.

A code from E000, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, misadventures or late effects.
Do not assign a code from category E000 if no other E codes (cause, activity) are applicable for the encounter.

Do not assign code E000.9, Unspecified external cause status, if the status is not stated.

Section II. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

In determining principal diagnosis the coding conventions in the ICD-9-CM, Volumes I and II take precedence over these official coding guidelines.
(See Section I.A., Conventions for the ICD-9-CM)

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

A. Codes for symptoms, signs, and ill-defined conditions

Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis

When there are two or more interrelated conditions (such as diseases in the same ICD-9-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions.

In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E. A symptom(s) followed by contrasting/comparative diagnoses

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

F. Original treatment plan not carried out

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

G. Complications of surgery and other medical care

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996-999 series and the code lacks the necessary

specificity in describing the complication, an additional code for the specific complication should be assigned.

H. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

I. Admission from Observation Unit

1. Admission Following Medical Observation

When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

2. Admission Following Post-Operative Observation

When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

J. Admission from Outpatient Surgery

When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.

A. Previous conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other

tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

C. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-9-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under "Conventions Used in the Tabular List." Information about the correct sequence to use in finding a code is also described in Section I.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of first-listed condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-9-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

1. Outpatient Surgery

When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

2. Observation Stay

When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.

When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes from 001.0 through V91.99

The appropriate code or codes from 001.0 through V91.99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate reporting of ICD-9-CM diagnosis codes

For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.

D. Selection of codes 001.0 through 999.9

The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g. infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).

E. Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the

provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.

F. Encounters for circumstances other than a disease or injury

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of factors Influencing Health Status and Contact with Health Services (V01.0- V91.99) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems. *See Section I.C. 18 for information on V-codes.*

G. Level of Detail in Coding

1. ICD-9-CM codes with 3, 4, or 5 digits

ICD-9-CM is composed of codes with either 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater specificity.

2. Use of full number of digits required for a code

A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.
See also discussion under Section I.b.3., General Coding Guidelines, Level of Detail in Coding.

H. ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

I. Uncertain diagnosis

Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

J. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

K. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

L. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign V72.5 and/or a code from subcategory V72.6. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

M. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy, radiation therapy, or rehabilitation, the appropriate V code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

N. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from category V72.8, Other specified examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

O. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

P. Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present, codes V22.0, Supervision of normal first pregnancy, or V22.1, Supervision of other normal pregnancy, should be used as the principal diagnosis. These codes should not be used in conjunction with chapter 11 codes.

Appendix I
Present on Admission Reporting Guidelines

Introduction

These guidelines are to be used as a supplement to the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

These guidelines are not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting*. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-9-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.

These guidelines are not a substitute for the provider's clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

General Reporting Requirements

All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.

Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.

Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.

If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

Reporting Options

Y - Yes
N - No
U - Unknown
W – Clinically undetermined
Unreported/Not used (or "1" for Medicare usage) – (Exempt from POA reporting)

Reporting Definitions

Y = present at the time of inpatient admission
N = not present at the time of inpatient admission
U = documentation is insufficient to determine if condition is present on admission
W = provider is unable to clinically determine whether condition was present on admission or not

Timeframe for POA Identification and Documentation

There is no required timeframe as to when a provider (per the definition of "provider" used in these guidelines) must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. Determination of whether the condition was present on admission or not will be based on the applicable POA guideline as identified in this document, or on the provider's best clinical judgment.

If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

Assigning the POA Indicator

Condition is on the "Exempt from Reporting" list

Leave the "present on admission" field blank if the condition is on the list of ICD-9-CM codes for which this field is not applicable. This is the only circumstance in which the field may be left blank.

POA Explicitly Documented

Assign Y for any condition the provider explicitly documents as being present on admission.

Assign N for any condition the provider explicitly documents as not present at the time of admission.

Conditions diagnosed prior to inpatient admission

Assign "Y" for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

Conditions diagnosed during the admission but clearly present before admission

Assign "Y" for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.

Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.

Condition develops during outpatient encounter prior to inpatient admission

Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

Documentation does not indicate whether condition was present on admission

Assign "U" when the medical record documentation is unclear as to whether the condition was present on admission. "U" should not be routinely assigned and used only in very limited circumstances. Coders are encouraged to query the providers when the documentation is unclear.

Documentation states that it cannot be determined whether the condition was or was not present on admission

Assign "W" when the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission.

Chronic condition with acute exacerbation during the admission

If the code is a combination code that identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to combination codes.

If the combination code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of chronic leukemia), assign "Y."

Conditions documented as possible, probable, suspected, or rule out at the time of discharge

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings suspected at the time of inpatient admission, assign "Y."

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings that were not present on admission, assign "N".

Conditions documented as impending or threatened at the time of discharge

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were present on admission, assign "Y".

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were not present on admission, assign "N".

Acute and Chronic Conditions

Assign "Y" for acute conditions that are present at time of admission and N for acute conditions that are not present at time of admission.

Assign "Y" for chronic conditions, even though the condition may not be diagnosed until after admission.

If a single code identifies both an acute and chronic condition, see the POA guidelines for combination codes.

Combination Codes

Assign "N" if any part of the combination code was not present on admission (e.g., obstructive chronic bronchitis with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission)

Assign "Y" if all parts of the combination code were present on admission (e.g., patient with diabetic nephropathy is admitted with uncontrolled diabetes)

If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign "Y".

For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later).

Same Diagnosis Code for Two or More Conditions

When the same ICD-9-CM diagnosis code applies to two or more conditions during the same encounter (e.g. bilateral condition, or two separate conditions classified to the same ICD-9-CM diagnosis code):

Assign "Y" if all conditions represented by the single ICD-9-CM code were present on admission (e.g. bilateral fracture of the same bone, same site, and both fractures were present on admission)
Assign "N" if any of the conditions represented by the single ICD-9-CM code was not present on admission (e.g. dehydration with hyponatremia is assigned to code 276.1, but only one of these conditions was present on admission).

Obstetrical conditions

Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator. The determining factor for POA assignment is whether the pregnancy complication or obstetrical condition described by the code was present at the time of admission or not.

If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign "Y".

If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign "N".

If the obstetrical code includes more than one diagnosis and any of the diagnoses identified by the code were not present on admission assign "N".

(e.g., Code 642.7, Pre-eclampsia or eclampsia superimposed on pre-existing hypertension).

If the obstetrical code includes information that is not a diagnosis, do not consider that information in the POA determination.

(e.g. Code 652.1x, Breech or other malpresentation successfully converted to cephalic presentation should be reported as present on admission if the fetus was breech on admission but was converted to cephalic presentation after admission (since the conversion to cephalic presentation does not represent a diagnosis, the fact that the conversion occurred after admission has no bearing on the POA determination).

Perinatal conditions

Newborns are not considered to be admitted until after birth. Therefore, any condition present at birth or that developed in utero is considered present at admission and should be assigned "Y". This includes conditions that occur during delivery (e.g., injury during delivery, meconium aspiration, exposure to streptococcus B in the vaginal canal).

Congenital conditions and anomalies

Assign "Y" for congenital conditions and anomalies**, except for categories 740-759, Congenital anomalies, which are on the exempt list.** Congenital conditions are always considered present on admission.

External cause of injury codes

Assign "Y" for any E code representing an external cause of injury or poisoning that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission)

Assign "N" for any E code representing an external cause of injury or poisoning that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission)

Categories and Codes
Exempt from
Diagnosis Present on Admission Requirement

Note: "Diagnosis present on admission" for these code categories are exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission.

Categories or subcategories listed are inclusive of all codes within those categories or subcategories, unless otherwise indicated. In order to streamline the POA exempt list and make it easier to read, where all of the codes in a code range are POA exempt, only the code range is shown, rather than listing each of the individual codes in the range.

137-139, Late effects of infectious and parasitic diseases

268.1, Rickets, late effect

326, Late effects of intracranial abscess or pyogenic infection

412, Old myocardial infarction

438, Late effects of cerebrovascular disease

650, Normal delivery

660.7, Failed forceps or vacuum extractor, unspecified

677, Late effect of complication of pregnancy, childbirth, and the puerperium

740-759, Congenital anomalies

905-909, Late effects of injuries, poisonings, toxic effects, and other external causes

V02, Carrier or suspected carrier of infectious diseases

V03, Need for prophylactic vaccination and inoculation against bacterial diseases

V04, Need for prophylactic vaccination and inoculation against certain viral diseases

V05, Need for other prophylactic vaccination and inoculation against single diseases

V06, Need for prophylactic vaccination and inoculation against combinations of diseases

V07, Need for isolation and other prophylactic or treatment measures

V10, Personal history of malignant neoplasm

V11, Personal history of mental disorder

V12, Personal history of certain other diseases

V13, Personal history of other diseases

V14, Personal history of allergy to medicinal agents

V15, Other personal history presenting hazards to health

V16, Family history of malignant neoplasm

V17, Family history of certain chronic disabling diseases

V18, Family history of certain other specific conditions

V19, Family history of other conditions

V20, Health supervision of infant or child

V21, Constitutional states in development

V22, Normal pregnancy

V23, Supervision of high-risk pregnancy

V24, Postpartum care and examination

V25, Encounter for contraceptive management

V26, Procreative management

V27, Outcome of delivery

V28, Antenatal screening

V29, Observation and evaluation of newborns for suspected condition not found

V30-V39, Liveborn infants according to type of birth

V42, Organ or tissue replaced by transplant

V43, Organ or tissue replaced by other means

V44, Artificial opening status

V45, Other postprocedural states

V46, Other dependence on machines and devices

V49.60-V49.77, Upper and lower limb amputation status

V49.81-V49.85, Other specified conditions influencing health status

V50, Elective surgery for purposes other than remedying health states

V51, Aftercare involving the use of plastic surgery

V52, Fitting and adjustment of prosthetic device and implant

V53, Fitting and adjustment of other device

V54, Other orthopedic aftercare

V55, Attention to artificial openings

V56, Encounter for dialysis and dialysis catheter care

V57, Care involving use of rehabilitation procedures

V58, Encounter for other and unspecified procedures and aftercare

V59, Donors

V60, Housing, household, and economic circumstances

V61, Other family circumstances

V62, Other psychosocial circumstances

V64, Persons encountering health services for specific procedures, not carried out

V65, Other persons seeking consultation

V66, Convalescence and palliative care

V67, Follow-up examination

V68, Encounters for administrative purposes

V69, Problems related to lifestyle

V70, General medical examination

V71, Observation and evaluation for suspected condition not found

V72, Special investigations and examinations

V73, Special screening examination for viral and chlamydial diseases

V74, Special screening examination for bacterial and spirochetal diseases

V75, Special screening examination for other infectious diseases

V76, Special screening for malignant neoplasms

V77, Special screening for endocrine, nutritional, metabolic, and immunity disorders

V78, Special screening for disorders of blood and blood-forming organs

V79, Special screening for mental disorders and developmental handicaps

V80, Special screening for neurological, eye, and ear diseases

V81, Special screening for cardiovascular, respiratory, and genitourinary diseases

V82, Special screening for other conditions

V83, Genetic carrier status

V84, Genetic susceptibility to disease

V85, Body Mass Index

V86, Estrogen receptor status

V87.32, Contact with and (suspected) exposure to algae bloom

V87.4, Personal history of drug therapy

V88, Acquired absence of other organs and tissue

V89, Suspected maternal and fetal conditions not found

V90, Retained foreign body

V91, Multiple gestation placenta status

E000, External cause status

E001-E030, Activity

E800-E807, Railway accidents

E810-E819, Motor vehicle traffic accidents

E820-E825, Motor vehicle nontraffic accidents

E826-E829, Other road vehicle accidents

E830-E838, Water transport accidents

E840-E845, Air and space transport accidents

E846-E848, Vehicle accidents not elsewhere classifiable

E849, Place of occurrence (Except E849.7)

E883.1, Accidental fall into well

E883.2, Accidental fall into storm drain or manhole

E884.0, Fall from playground equipment

E884.1, Fall from cliff

E885.0, Fall from (nonmotorized) scooter

E885.1, Fall from roller skates

E885.2, Fall from skateboard

E885.3, Fall from skis

E885.4, Fall from snowboard

E886.0, Fall on same level from collision, pushing, or shoving, by or with other person, In sports

E890.0-E890.9, Conflagration in private dwelling

E893.0, Accident caused by ignition of clothing, from controlled fire in private dwelling

E893.2, Accident caused by ignition of clothing, from controlled fire not in building or structure

E894, Ignition of highly inflammable material

E895, Accident caused by controlled fire in private dwelling

E897, Accident caused by controlled fire not in building or structure

E917.0, Striking against or struck accidentally by objects or persons, in sports without subsequent fall

E917.1, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic without subsequent fall

E917.2, Striking against or struck accidentally by objects or persons, in running water without subsequent fall

E917.5, Striking against or struck accidentally by objects or persons, object in sports with subsequent fall

E917.6, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic with subsequent fall

E919, Accident caused by machinery (Except E919.2)

E921, Accident caused by explosion of pressure vessel

E922, Accident caused by firearm and air gun missile

E926.2, Visible and ultraviolet light sources

E928.0-E928.8, Other and unspecified environmental and accidental causes

E929.0-E929.9, Late effects of accidental injury

E959, Late effects of self-inflicted injury

E970-E978, Legal intervention

E979, Terrorism

E981, Poisoning by gases in domestic use, undetermined whether accidentally or purposely inflicted

E982, Poisoning by other gases, undetermined whether accidentally or purposely inflicted

E985, Injury by firearms, air guns and explosives, undetermined whether accidentally or purposely inflicted

E987.0, Falling from high place, undetermined whether accidentally or purposely inflicted, residential premises

E987.2, Falling from high place, undetermined whether accidentally or purposely inflicted, natural sites

E989, Late effects of injury, undetermined whether accidentally or purposely inflicted

E990-E999, Injury resulting from operations of war